Smart Health

User Guide

Version: 7.3

Issue Date: 22 August 2014

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1. INTRODUCTION

Smart Health uses conventional computer application design and features to provide a familiar experience to clinical users.

- A Menu bar (at the top of the application window) for most application functions, such as opening and closing patient records, logging out, printing records, attaching documents, creating new services and forms, accessing external resources and web sites and downloading reporting databases.
- A navigation tree (at the left of the main application window) to move between the major elements of the patient record. Each level in the navigation tree can be expanded and collapsed by clicking on the plus or minus sign that appears to the left of the text for that level.

Other features of the application include:

a. Right click sub-menu to copy and paste selected text

b. The use of hyperlinks (indicated by a “hand” cursor) to move between parts of the patient record

c. Movement between any number of open forms and sections of the health record without having to first close forms or navigation trees

d. Reminders from the application if you try and close forms that have not been saved

e. Clicking the Esc(ape) key cancels the current activity and returns the user to the previous screen; if a form has been partially completed prior to clicking Escape, the user is prompted to discard the changes (or save the record).

f. The creating user in most forms defaults to the logged on user

g. Mandatory fields are highlighted in Yellow

h. Fields with invalid data are highlighted in Pink

Details of the currently logged in user are always displayed in the top left corner of the application window (above the navigation bar).

Details of the currently open patient are also always displayed in the top left corner of the application window (above the Navigation Bar).

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2. USER INTERFACE CONVENTIONS

Smart Health implements a number of standard conventions in its user interface. These conventions are common across all service records and on-line forms.

Selecting a provider	Providers are selected using a tool that displays lists of providers that are in the Smart Health provider directory. For most service records, the list will default to providers from the logged in user's medical group and may be limited to the roles that are appropriate to the field being selected. Options allow users to search for other providers and to add non-participating providers and non-participating medical groups to the provider directory.
Tabs	Some Service Records use Tabs to divide up data across the screen, to avoid the need for scrolling down (and up the service record window).
Non-editable selection lists	Many text selection lists (drop down lists) contain a fixed set of entries, one of which can be selected by the user (or must be selected by the user if the field is mandatory). It is not possible to enter any value other than those in the drop down list.
Editable selection lists	Editable text selection lists (drop down lists) allow users to type their own text into the field if the options in the drop down list are not appropriate. Text that is typed in by users is not added to the drop down list options (please ask Smart Health to add options to a drop down list if this is required).
Mandatory fields	Mandatory fields are highlighted in yellow in Smart Health service records. Service records that can only be saved as "final" cannot be saved until all mandatory fields have been completed.
Fields with invalid data	Fields that contain invalid data are highlighted in pink. For example, this includes numeric fields where the data that has been entered is outside the allowable values for the field.

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Dates	Dates can be entered in several ways, including using a drop down date picker or typing the date directly into the field using one of several standard conventions. When typing dates (and times), slashes between day, month and year are optional, colons between hours and minutes are optional and year can be in “yy“ or “yyyy“ format. Some date fields accept partial dates (year or month and year only).
Check boxes	Check boxes are used to broaden the selection of displayed service records. For example, when the Medication Summary is selected, it displays current medications only by default. Selecting the Display All check box also displays historical medications.
Edit	Service records that can be edited have an Edit button at the bottom of the screen. In some cases, separate groups of fields within an on-line form may be editable.
Close	Service records have a Close button that can be selected to close the record (to de-clutter the patient view). It is not necessary to Close patient records before closing the patient. If you close a patient while unsaved service records are open, you will be reminded to save those service records before the patient is closed.
Cancel	When a service record is being created or edited, or a dialog has been opened to enter service record data, a Cancel button can be used to cancel the current action and return to the previous state.
Save	The Save button, displayed when a service record is being created or edited, saves the service record to the Smart Health database. Service Records that can only be saved “final” must have all mandatory fields completed before they can be saved.

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Save draft	Some service records can be saved as Draft records. A Save Draft button is displayed in addition to a Save (Save Final) button. Service records that support drafts can be saved as drafts while mandatory fields remain uncompleted.

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3. PATIENT CONSENT, SECURITY AND ACCESS CONTROL

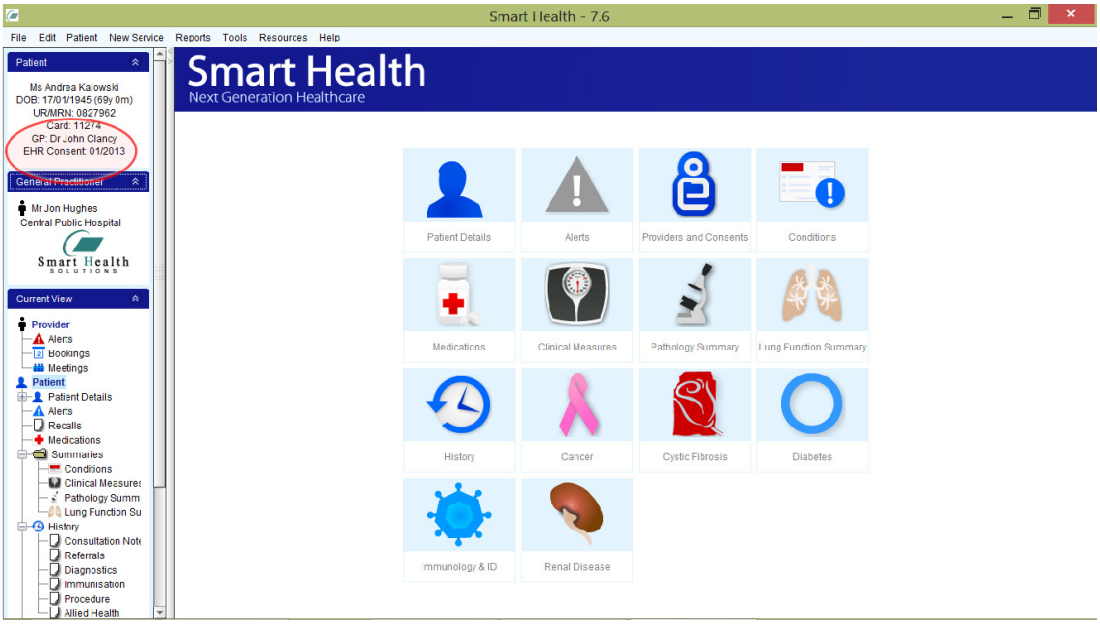
3.1 Patient Consent

Patients are automatically assumed to have provided health record consent to the practice that initially registers them in Smart Health and that creates their on-line health records.

Smart Health also allows patient health records to be accessed across many practices, subject to patient consent. Patients normally nominate the practices that they wish to be able to access their records when they agree to join the EHR program. EHR program administrators can create patient relationships with these practices using Administration functions (Administration User Guide).

Users (healthcare providers) can only view the on-line health records of patients that have consented for their practice to have access to those records.

If a patient has consented to participate in a shared electronic health record program, this is recorded in the Smart Health patient demographic details and displayed in the Patient summary in the Navigation tree and at the top of the Patient demographic details pane:



When the EHR consent has been completed for a patient, “Referral” Services are enabled in the New Service menu:

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Referrals allow users to refer the patient to other healthcare providers, including to providers in other practices. Consent to view the patient's on-line health record is also transferred to the new practice.

3.2 Security and Access Control

Each Smart Health user has a role (such as Administrator, Nurse, GP, Specialist, Allied Health, Technician, etc.). Each role defines an initial set of permissions to view and update various elements of patients' on-line health records. For example, an Administrator cannot normally view (or update) patient clinical information; an Allied Health provider or Nurse cannot Prescribe, and so on.

Your permissions will determine which parts of a patient's health record you can view and which parts you can update.

Each user's permissions can be modified by a local Administrator, using the Administration functions (Administration User Guide), if required to reflect that user's actual job and information management responsibilities.

3.3 Confidentiality

Many health event summary records in Smart Health have a Confidentiality setting that is assigned when the record is created.

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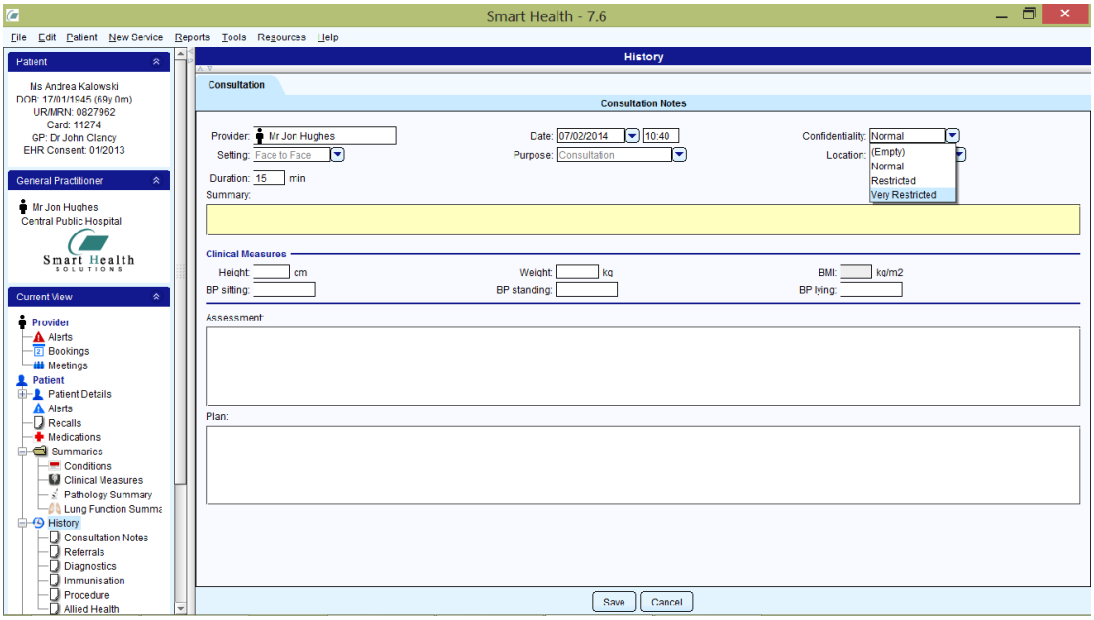

The default Confidentiality is Normal and this does not normally need to be changed.

In some circumstances, the Confidentiality of an event record may need to be changed to reflect the sensitive nature of information that has been recorded in that event summary:

Restricted	Only accessible by members of the creating medical group (practice), regardless of patient consent and other users' permissions
Very Restricted	Only accessible by the creating provider, regardless of patient consent and other users' permissions

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4. ALERTS AND NOTIFICATIONS

Various events in Smart Health may cause participating users to be Alerted that these events have occurred.

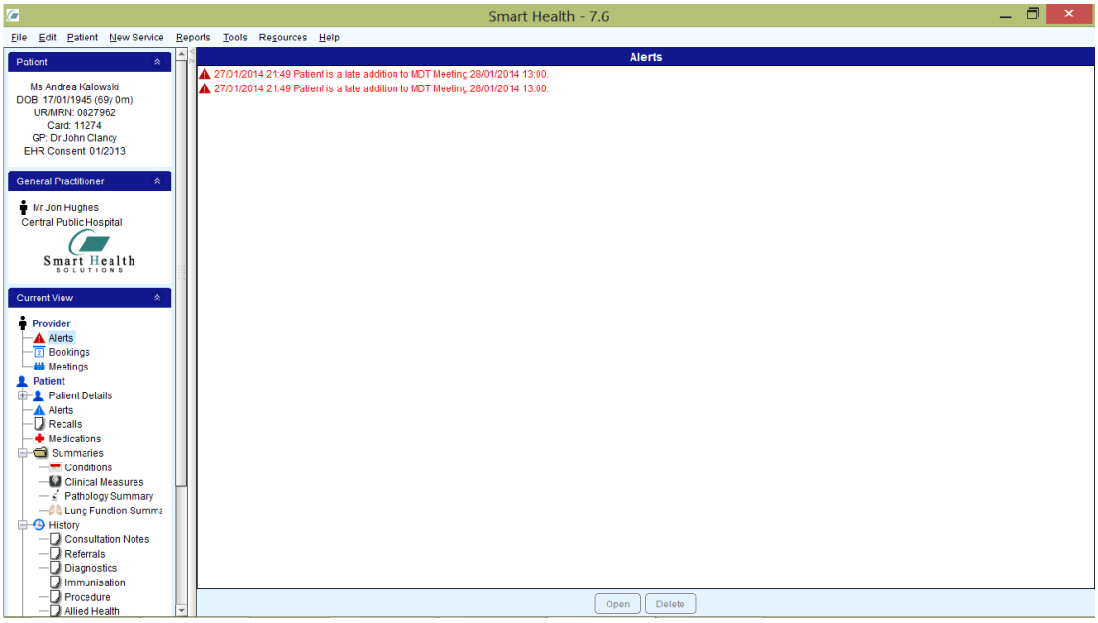
For example, if a patient is referred to you by another user using the on-line Referral function (New Service/Referral), you will be alerted to this next time you log on to Smart Health.

Alerts may also generate e-mails and/or SMSs to users (and to patients), if users and patients wish to receive electronic notifications.

4.1 Alerts

New Alerts are notified to users as a “pop up” message that must be acknowledged before the user can continue.

Alerts for all patients are displayed in the Alerts pane of the Provider view in the Navigation tree. Alerts for the currently open patient (if one is open) are displayed in the Alerts pane of the Patient record in the Navigation tree.



A user can choose whether or not to receive Alerts. An Administrator can use Administration functions to change a user’s Alert notification profile.

4.2 SMS

User Alerts also generate SMSs to the User if this feature has been configured in the User’s profile.

An Administrator can use Administration functions to change a user’s SMS notification profile.

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4.3 Emails

User Alerts also generate eMails to the User if this feature has been configured in the User's profile.

An Administrator can use Administration functions to change a user's Email notification profile.

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5. LOG ON TO SMART HEALTH

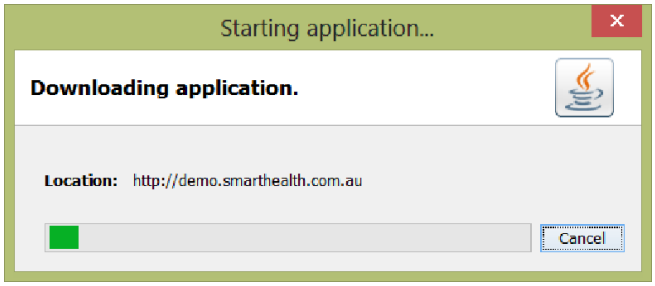
5.1 Workstation & Network Logon

Logon to the PC and/or local network

5.2 Logon to Smart Health

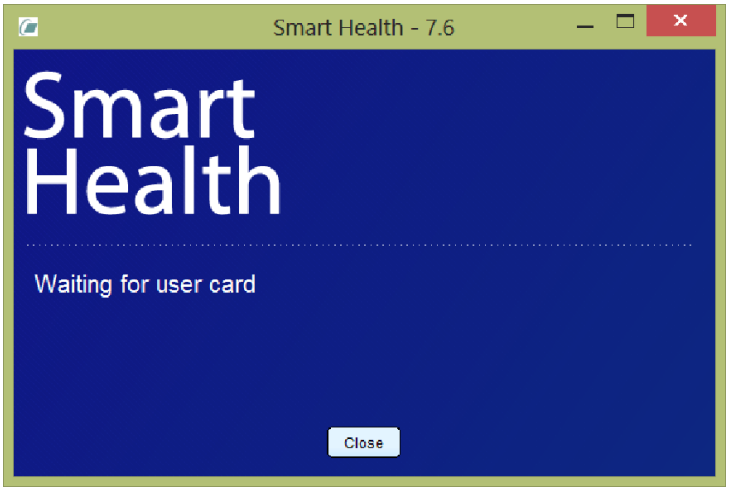
Click Smart Health icon on the desktop or use the Start button to Start Smart Health

Smart Health checks for the latest release of the Application, which is usually updated at least three time per year. You may see the following window while the application downloads the latest updates before continuing to start:



Each user is issued with a smartcard that contains his or her individual, unique keys. Your card is used to identify and authenticate you and to ensure that patient clinical information is exchanged securely with the Smart Health Server.

When the following screen appears, insert your Card into the card reader slot, with the chip facing up and closest to the reader.



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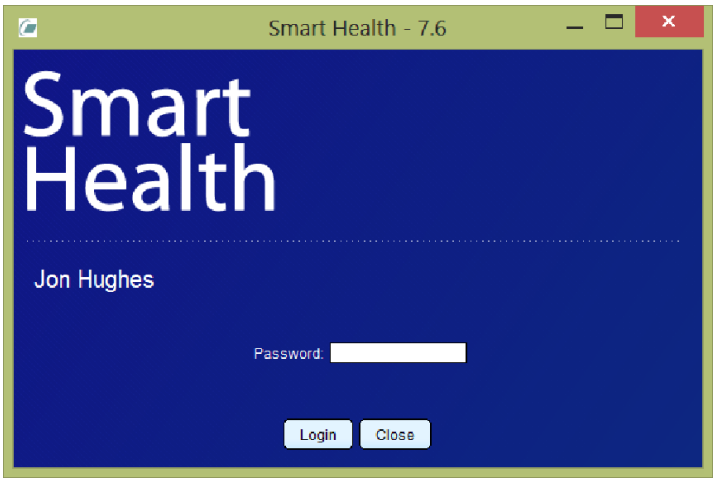
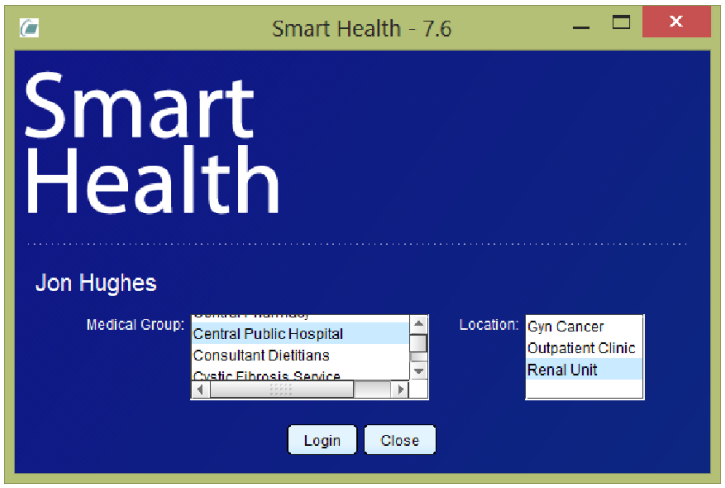
5.3 Password

The system displays the following password entry screen:



Type in your password and press Enter or click the Login button; the password is case sensitive; you are only three (3) password attempts before the card is locked, requiring it to be replaced[1].

If you are registered with more than one Smart Health practice (medical group), you will be prompted to select the appropriate Medical Group and, optionally, your Location – then click Login:



[1] If a card becomes locked, you need to apply for a replacement from the Department of Human Services. Go to http://www.medicareaustralia.gov.au/provider/vendors/pki/forms.jsp, download the Revocation/suspension/reinstatement/renewal request form, complete it and send it to Medicare Australia.

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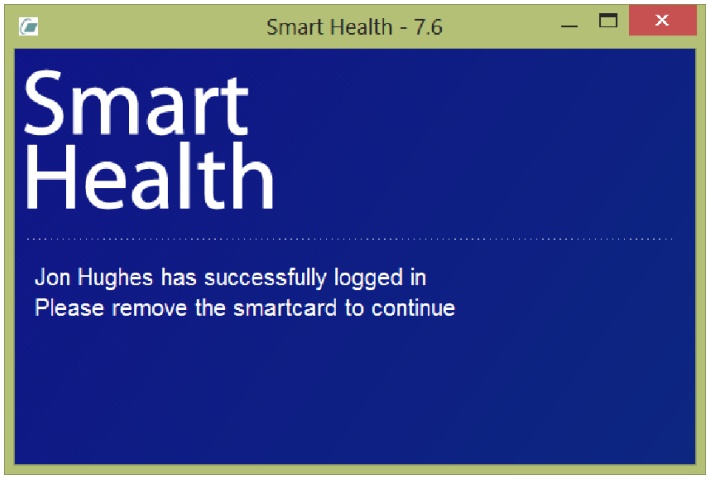
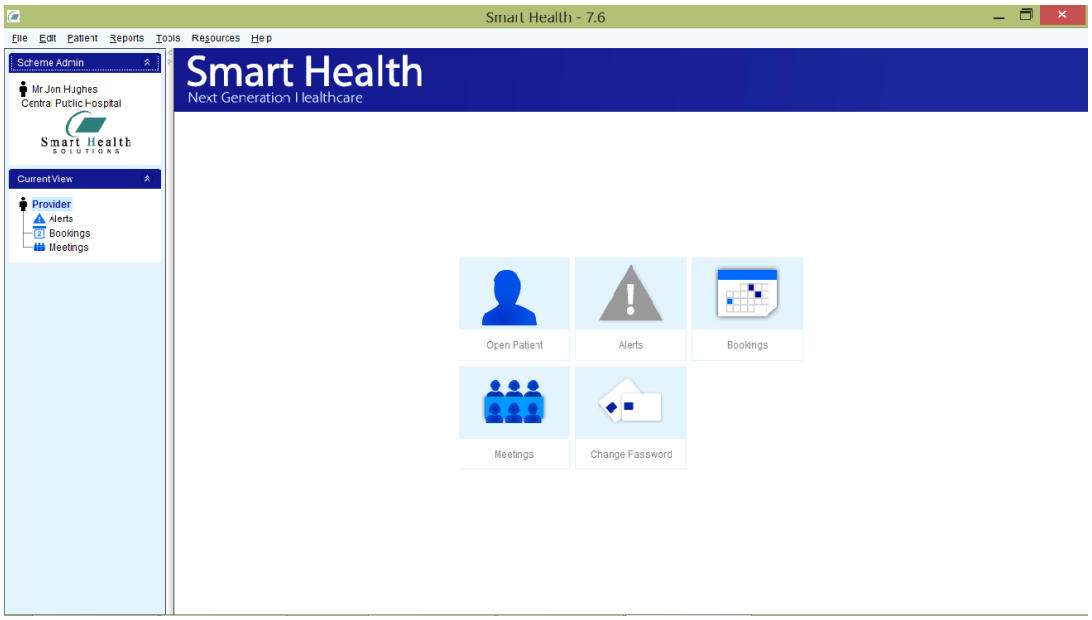
The system requests that your card remains in the card reader until it has checked the validity of the password entered and has established a secure connection to the Smart Health server. Please do not remove your card from the reader until prompted to do so.

5.4 Logon Complete

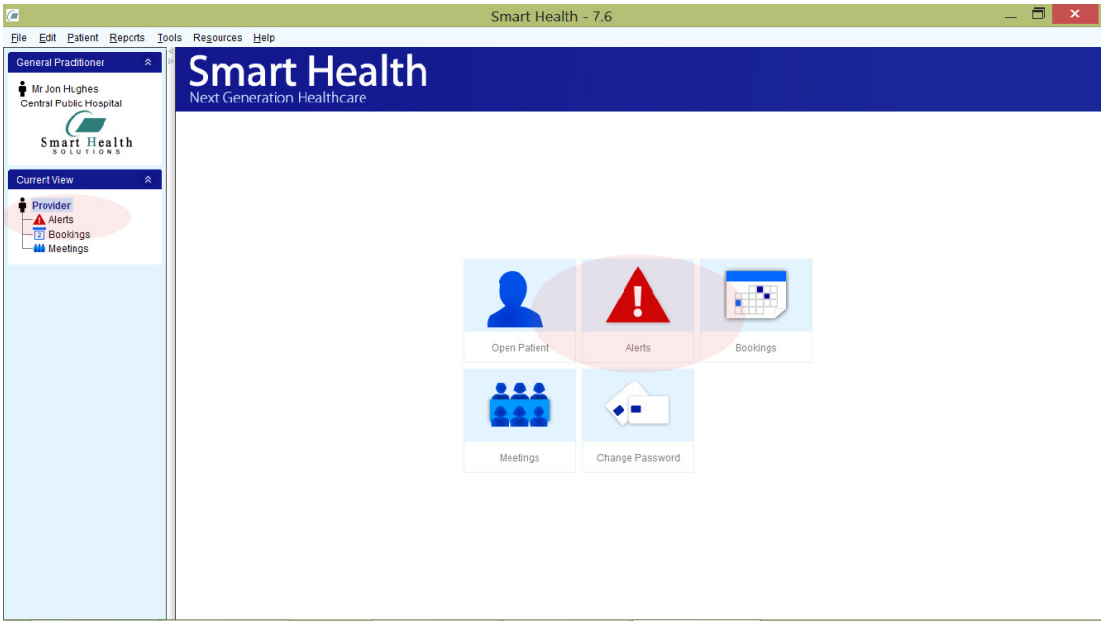
When login is complete, you are prompted to remove you Provider Card from the card reader;



When you remove your smartcard, Smart Health is ready to open patient records:



If you have unread Alerts, the Alert icon (and Alert entry in the navigation tree) are highlighted in red.



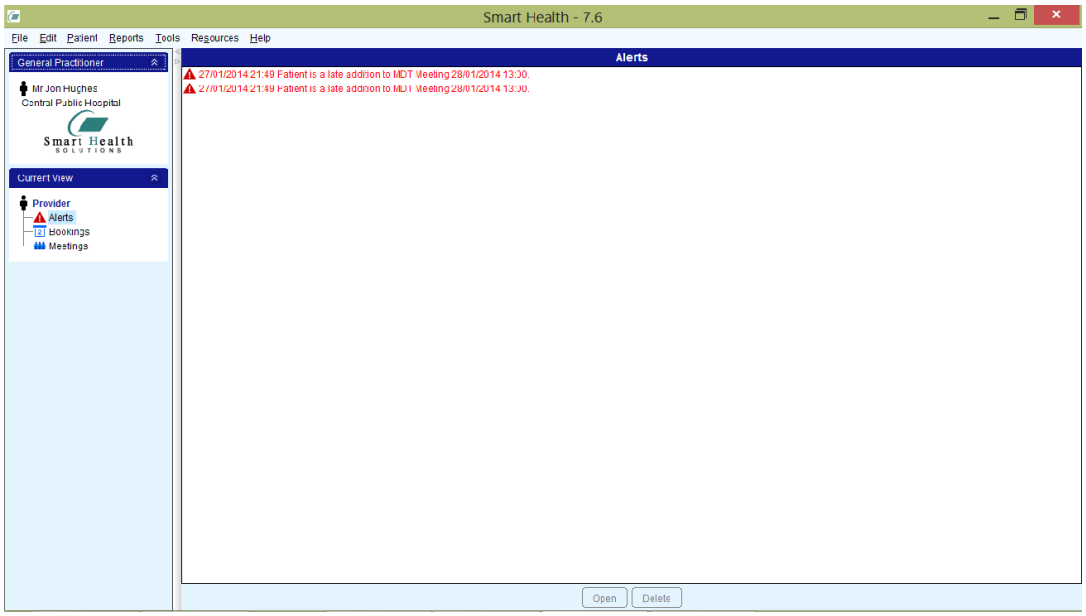
6. PROVIDER VIEW

The Provider View (User View) is the top part of the Navigation tree where information for the User is presented. It displays information about Alerts, Bookings and Meetings.

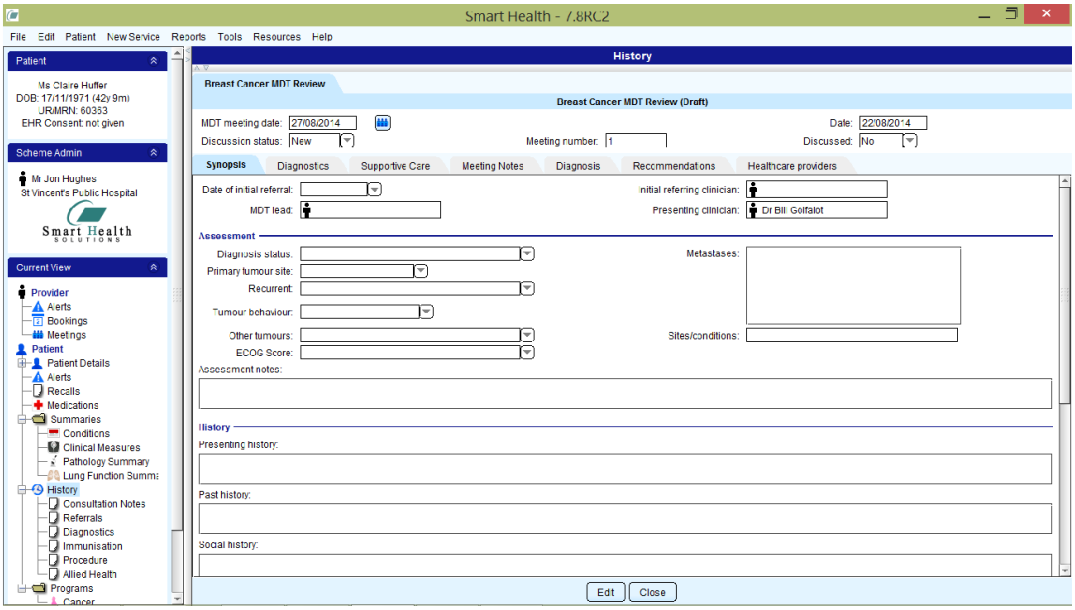
Bookings and Meetings are described later in this user guide.

6.1 Alerts

When a specific patient record is not open, the Alerts view displays all of the user's patients (for all patients).

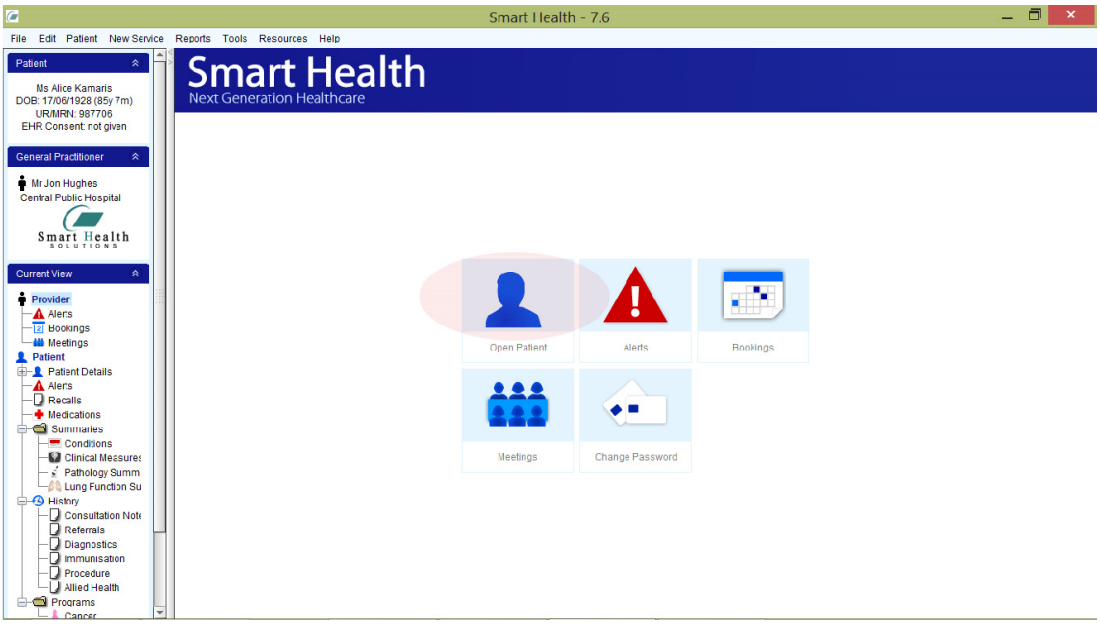


Double click an Alert to open the patient's record and display the reason for the Alert (in this case, the patient has been added to the agenda for an MDT Meeting) and an MDT Review record has been created:

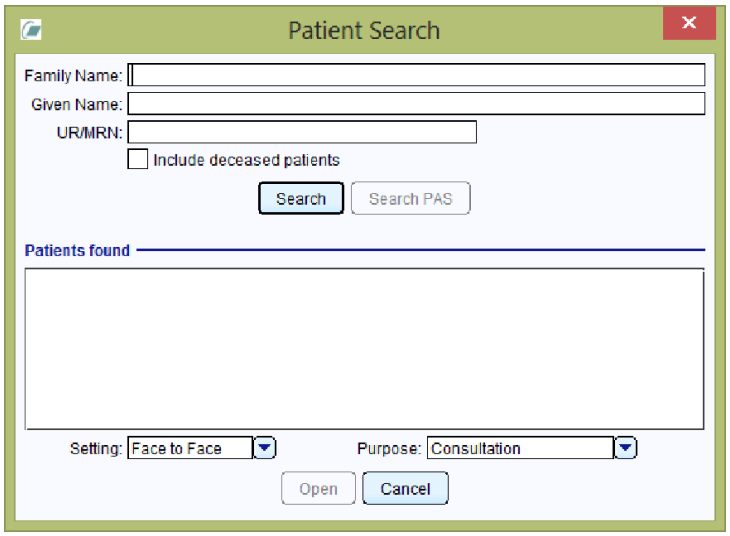

Smart Health - 7.8RC2
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Claire Huffer
DOB: 17/11/1971 (42y 9m)
URMRN: 60353
EHR Consent: not given
Scheme Admin
Mr Jon Hughes
St Vincent's Public Hospital
Smart Health
SOLUTIONS
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Programs
Cancer
History
Breast Cancer MDT Review
Breast Cancer MDT Review (Draft)
MDT meeting date: 27/08/2014
Discussion status: New
Meeting number: 1
Date: 22/08/2014
Discussed: No
Synopsis
Diagnostics
Supportive Care
Meeting Notes
Diagnosis
Recommendations
Healthcare providers
Date of initial referral:
MDT lead:
Initial referring clinician:
Presenting clinician: Dr Bill Golfalot
Assessment
Diagnosis status:
Primary tumour site:
Recurrent:
Tumour behaviour:
Other tumours:
ECOG Score:
Metastases:
Sites/conditions:
Assessment notes:
History
Presenting history:
Past history:
Social history:
Edit
Close

7. OPEN PATIENT

Open a patient record by clicking the Open Patient button or by selecting Open Patient from the Smart Health File menu:



This opens the Search Patient dialog:



- Type two or more letters of the patient's Family name or type a UR/MRN
- Click Search or press Enter
- You can also include deceased patients in the search by clicking the check box at the bottom of the window.

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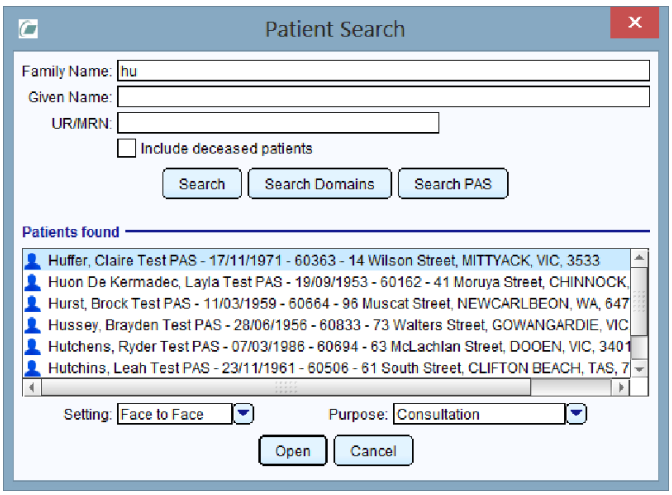
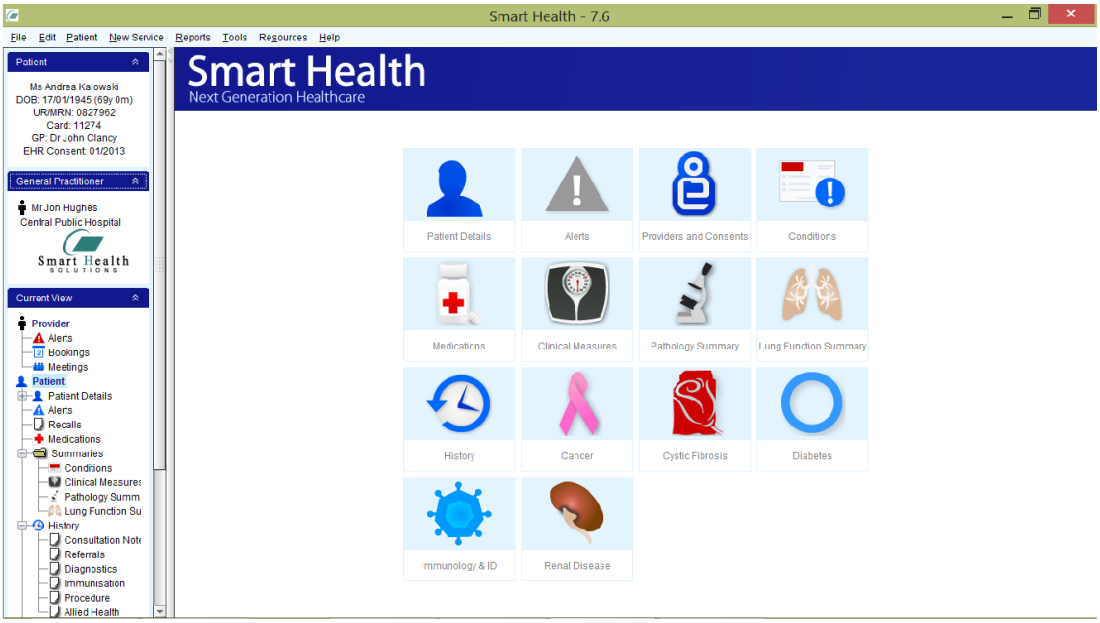
If the patient you wish to open is not found and Smart Health is linked to your hospital's Patient Administration System (PAS), the Search PAS button in the Patient Search dialog will now be active. Click Search PAS to search the PAS for the patient:


Patient Search
Family Name: hu
Given Name:
UR/MRN:
Include deceased patients
Search
Search Domains
Search PAS
Patients found
Huffer, Claire Test PAS - 17/11/1971 - 60363 - 14 Wilson Street, MITTYACK, VIC, 3533
Huon De Kermadec, Layla Test PAS - 19/09/1953 - 60162 - 41 Moruya Street, CHINNOCK,
Hurst, Brock Test PAS - 11/03/1959 - 60664 - 96 Muscat Street, NEWCARLBEON, WA, 647
Hussey, Brayden Test PAS - 28/06/1956 - 60833 - 73 Walters Street, GOWANGARDIE, VIC
Hutchens, Ryder Test PAS - 07/03/1986 - 60694 - 63 McLachlan Street, DOOEN, VIC, 3401
Hutchins, Leah Test PAS - 23/11/1961 - 60506 - 61 South Street, CLIFTON BEACH, TAS, 7
Setting: Face to Face
Purpose: Consultation
Open
Cancel

Select the appropriate values for Setting and Purpose, select the correct patient and click Open (or double click the correct patient).

The patient details are retrieved and the patient record is opened. The navigation tree provides links to all of the components of the patient record; buttons provide links to key components of the record.



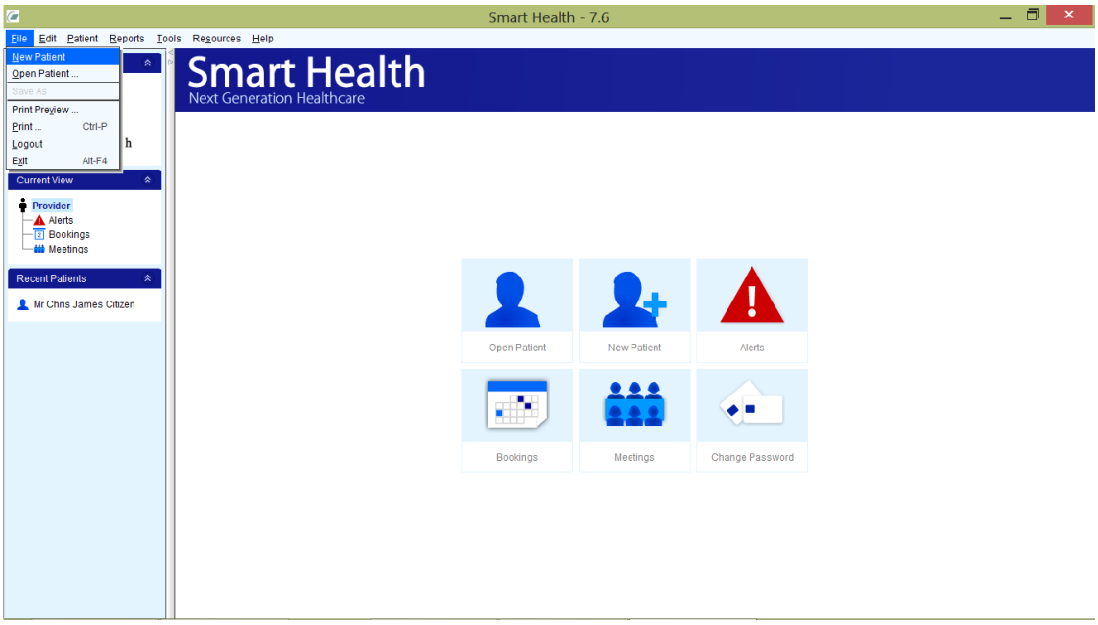
8. NEW PATIENT

New patient details are usually imported from clients' patient administration systems but can also be created within Smart Health. When creating a patient record, the user can choose to create a fully detailed patient record, or if the user is pressed for time, he or she can create a brief patient record.

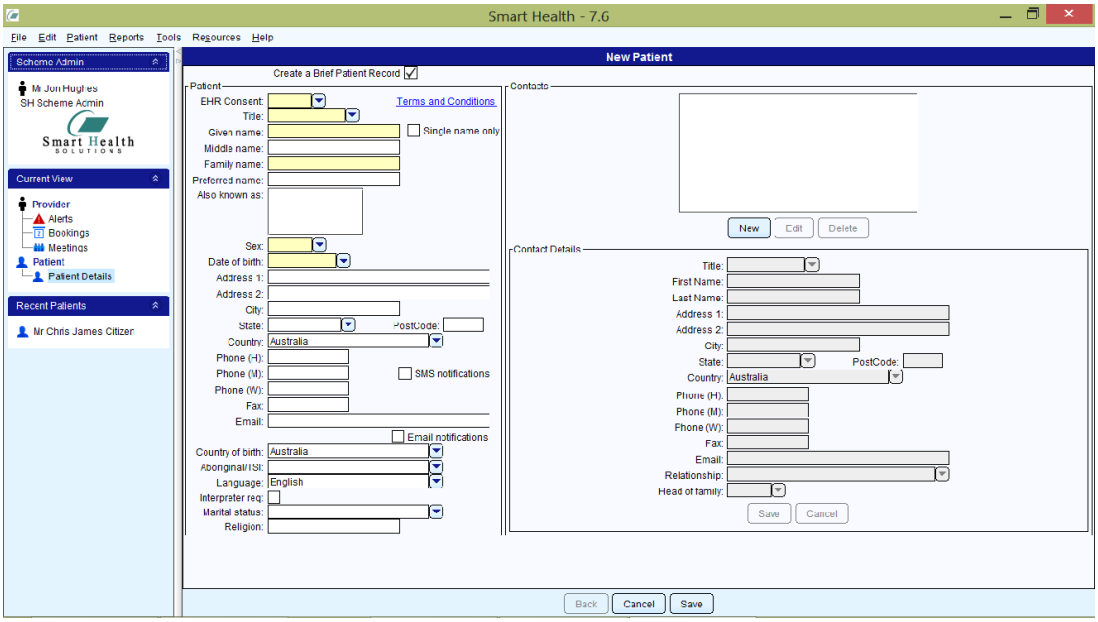
All patient records must be closed before you can create new patient record.

8.1 Create Brief Patient Record

Select New Patient from the File main menu or click the New Patient button.



Check the "Create Brief Patient Record" check box:



The only fields that must be completed to create the new patient record are:

- First name
- Surname
- Title
- Date of Birth
- Sex

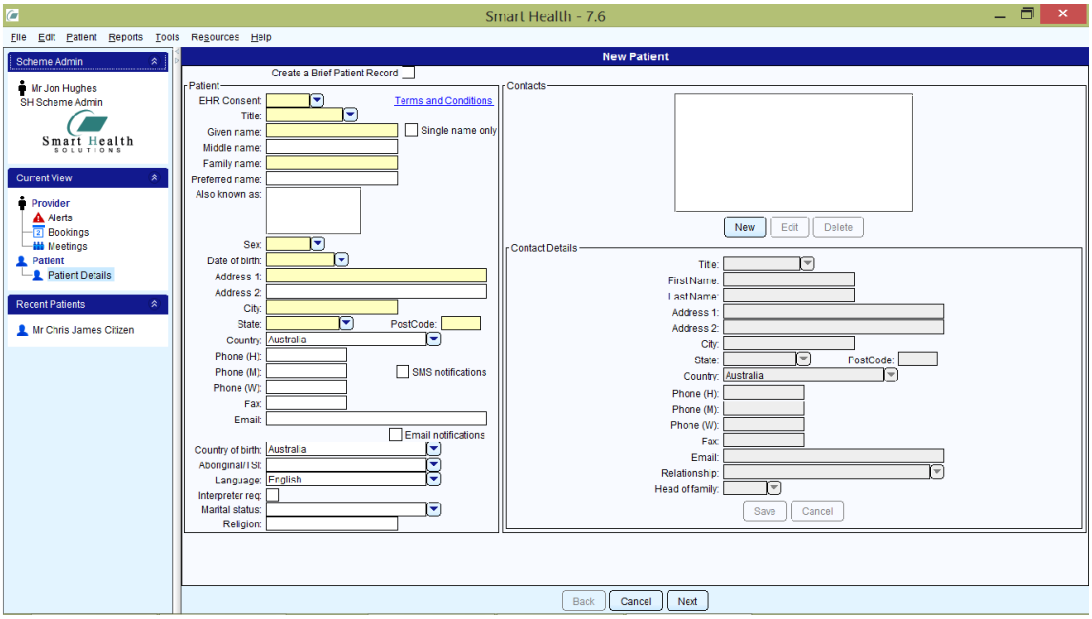
Enter the patient's details and click Save. A message will be displayed reminding you that this patient's record will need to be updated with additional details at a later time.

8.2 Create Full Patient Record

Select New Patient from the File main menu or click the New Patient button.

8.2.1 Demographic Details

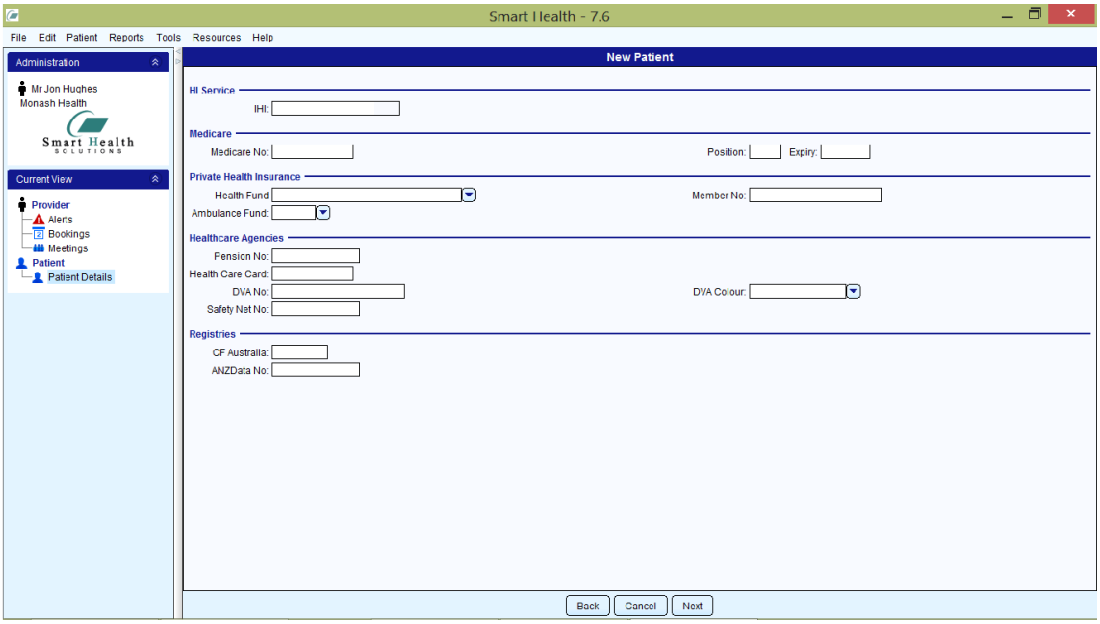
Complete the patient's details, including all those that are mandatory (yellow).



Click New in the Contacts pane to add contact person details. Contacts may include next of kin, carers, guardians, powers of attorney or anyone nominated by the patient.

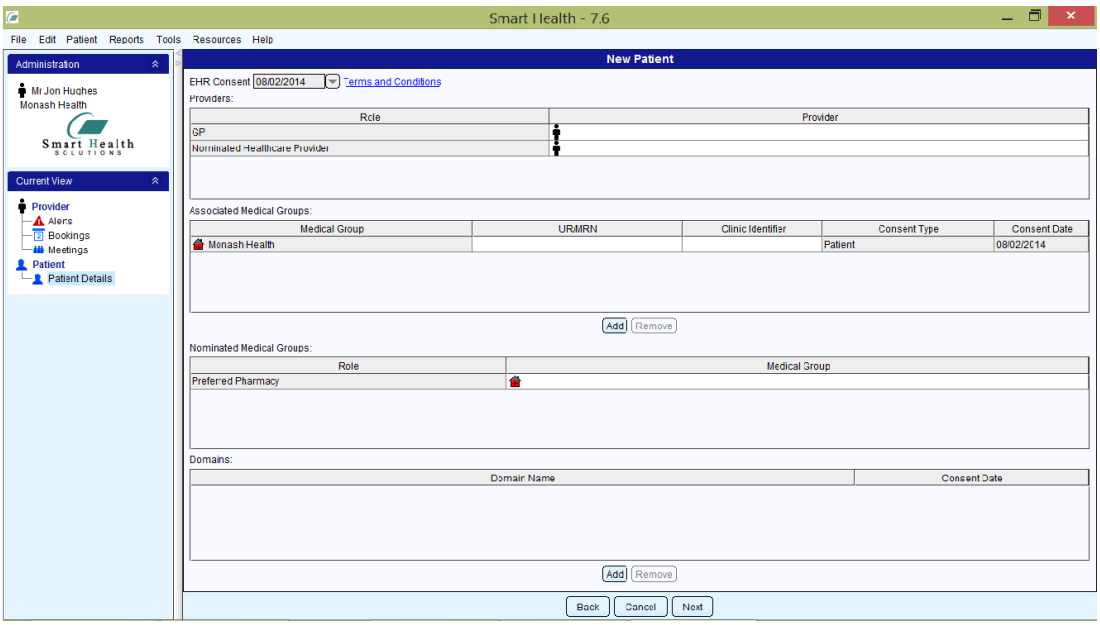
When all of the patient's demographic details are complete, click Next to display the insurance and identifiers form

8.2.2 Insurance and Identifiers



Complete the patient's insurance and other identifiers, if known and click Next.

8.2.3 *Providers and Medical Groups*



Enter the patient's:

- GP
- Nominated healthcare provider (authorised to create Shared Health Summaries in the national PCEHR system)
- Associated Medical Groups (consent to view the patient's health records) –entering the patient's UR/MRN for a practice will register the patient for automated updates of administrative and clinical data for some health services
- Nominated Medical Groups (practices with which the patient has a specific relationship)
- Domains (shared health record programs for groups of practices that are participating in a collaborative healthcare program for patients)

And click Next

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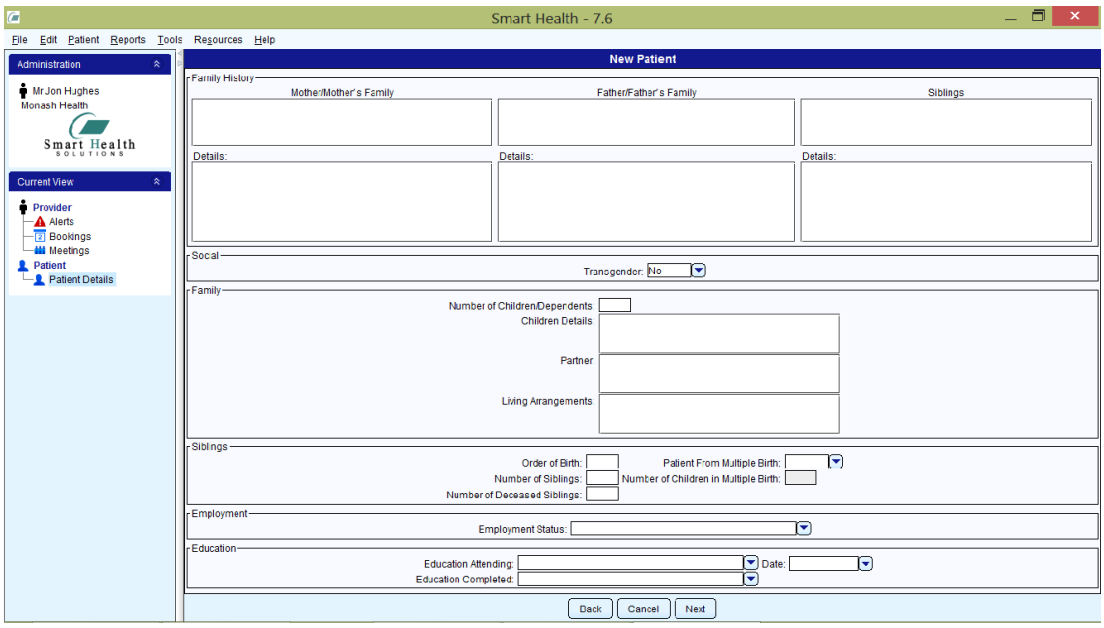
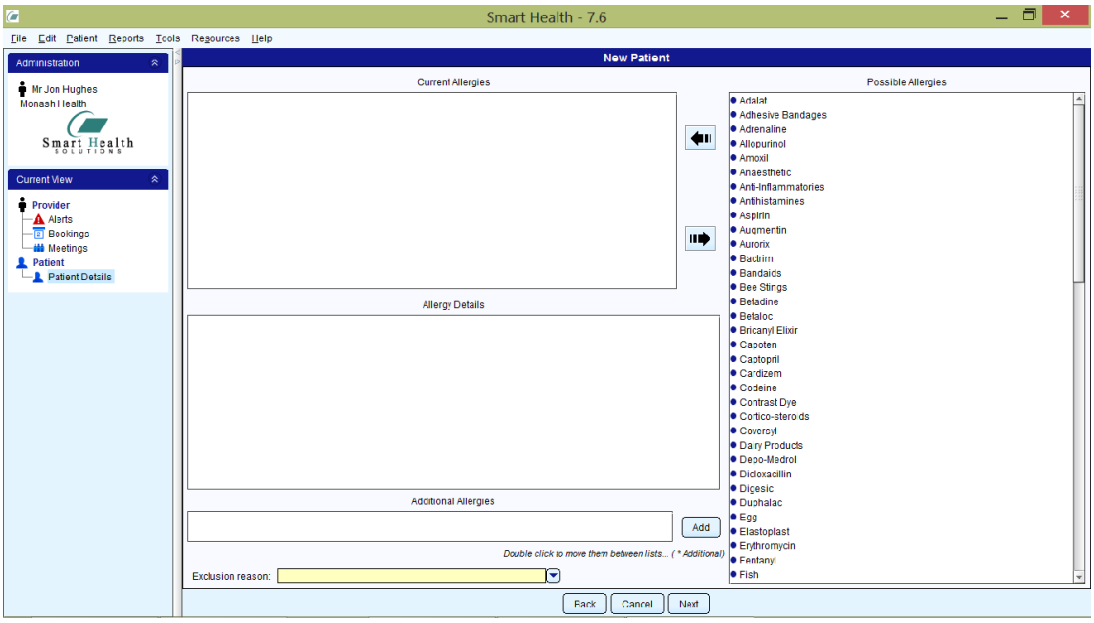
8.2.4 *Family Social*



Enter the patient's relevant family medical history and psycho-social data and click Next.

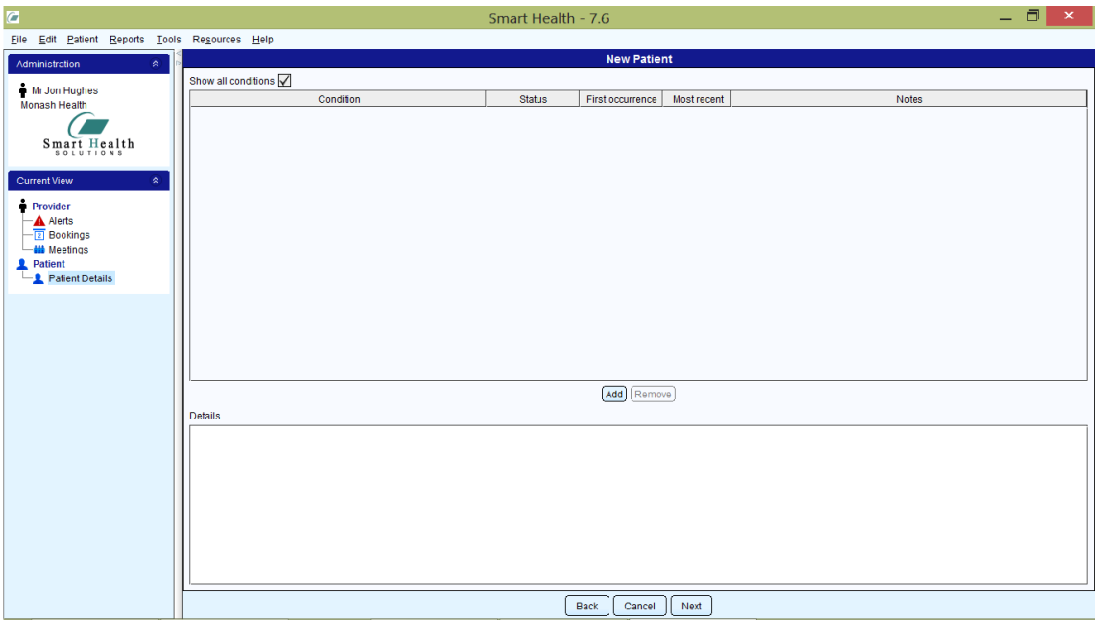
8.2.5 *Allergies*



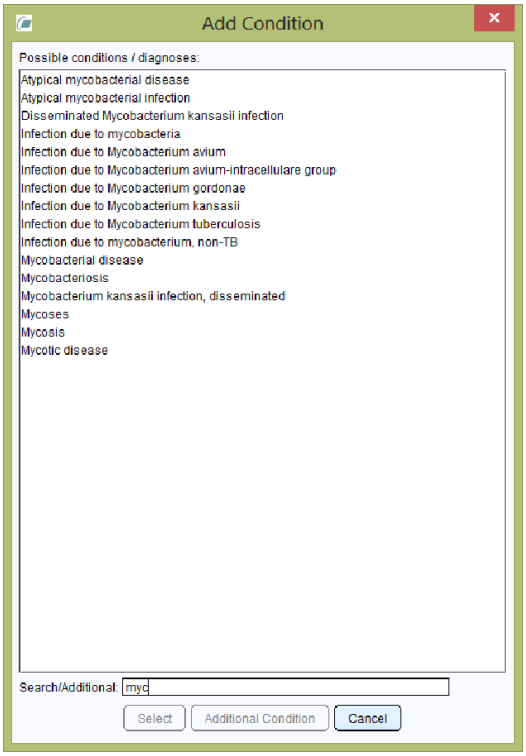
Select allergies in the right hand pane and click the arrows between the panes to add them to, or remove them from the patient's profile. Add allergy details where known. Additional allergies may be added by typing details in Additional Allergies and clicking Add.

Select an Exclusion Reason if no allergies are recorded and click Next.

8.2.6 *Conditions/Diagnoses*



Click the Add button to record Conditions for the patient. Use the Search/Additional field to find Conditions:



Additional conditions can be added by typing the Condition name in the Search/Additional field, and if no matching Condition is found, clicking the Additional Condition button.

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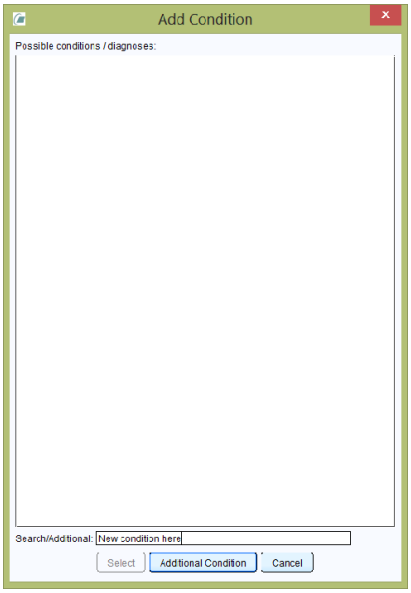
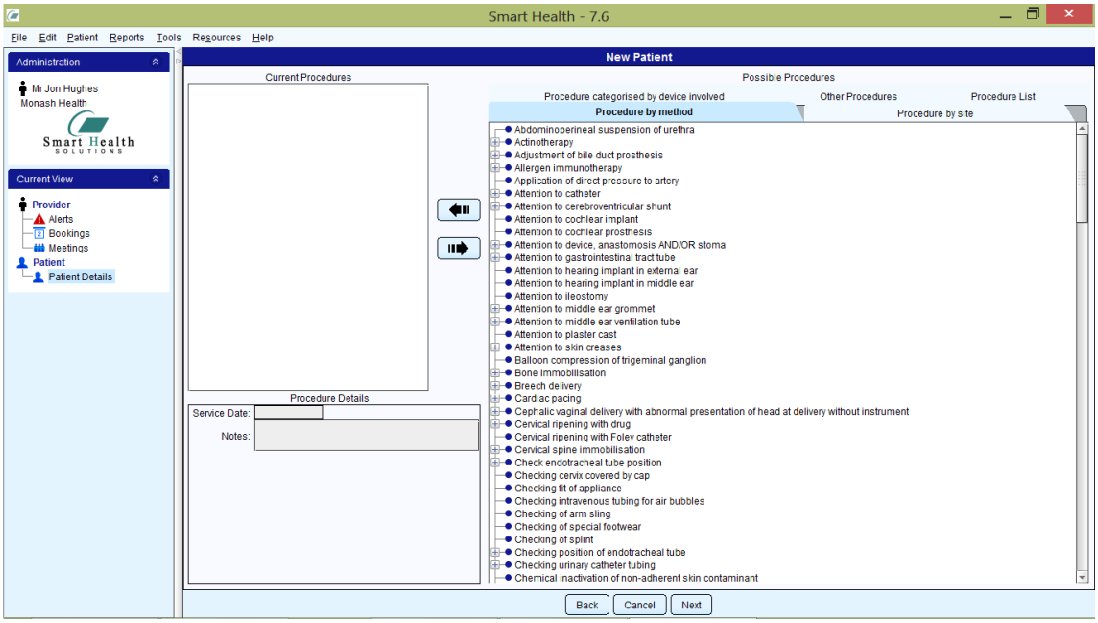


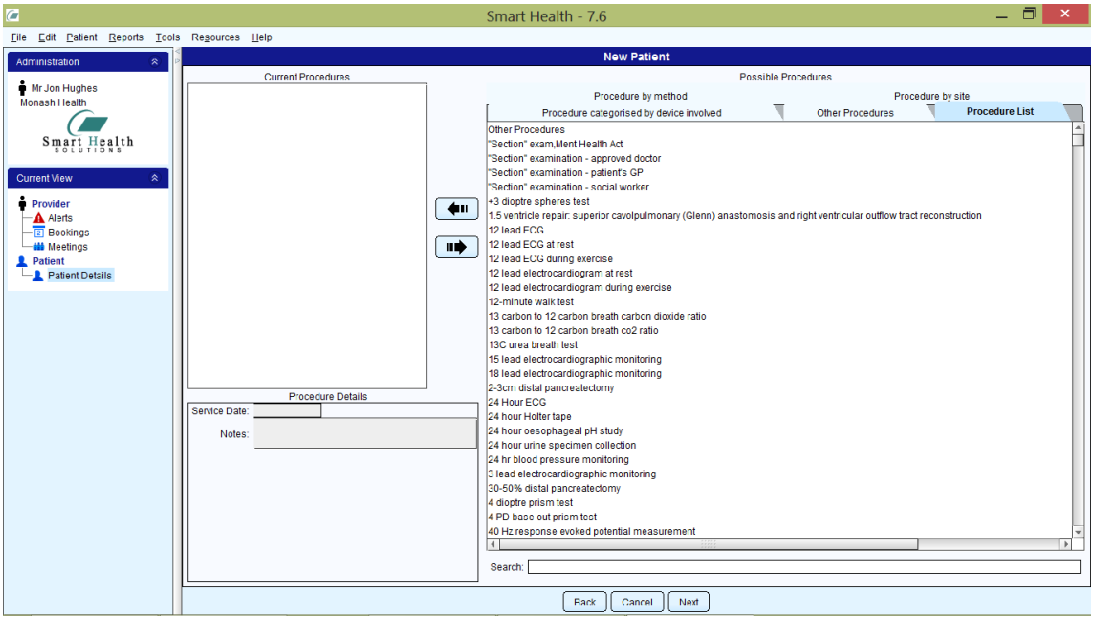
When all conditions/diagnoses have been entered, click Next.

8.2.7 Procedures



Select Procedures in the right hand pane and click the arrows between the panes to add them to, or remove them from the patient's profile. Additional information relating the selected procedures can be added in the left hand lower pane.

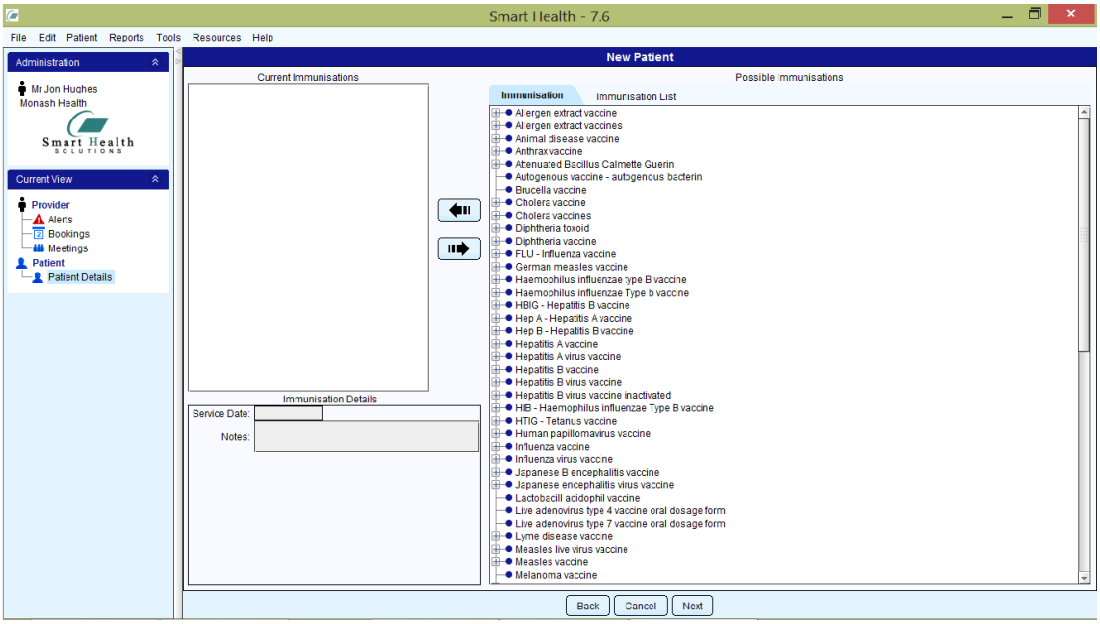
The Procedure List tab in the right hand pane includes a Search function to find Procedures:



Procedures are saved as clinical event records.

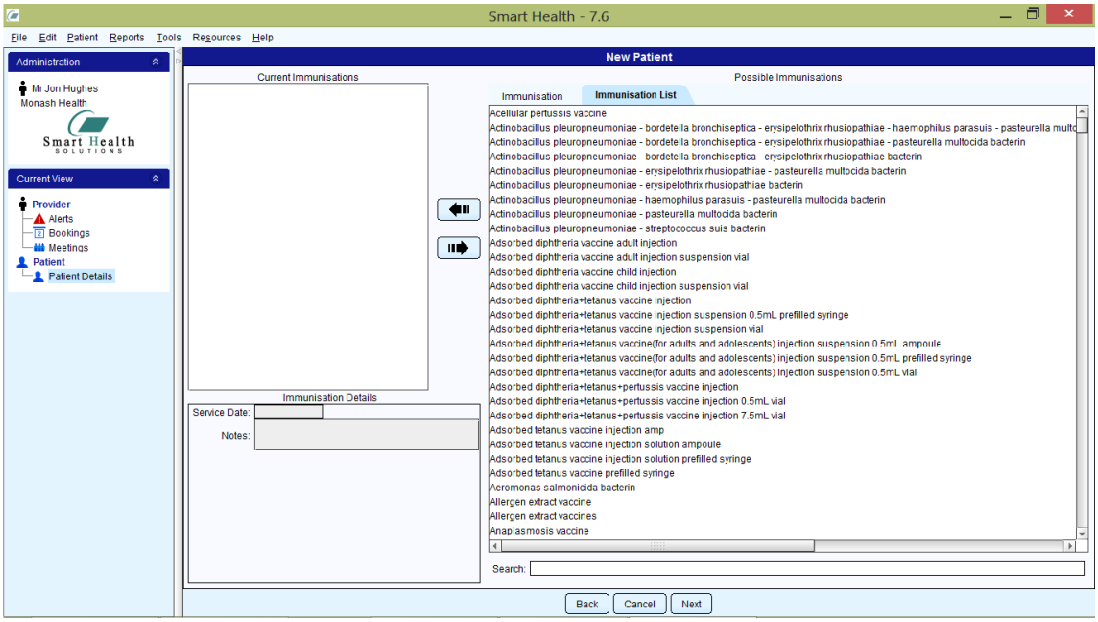
When all procedures have been entered, click Next.

8.2.8 Immunisations



Select Immunisations in the right hand pane and click the arrows between the panes to add them to, or remove them from the patient's profile. Additional information relating the selected Immunisations can be added in the left hand lower pane.

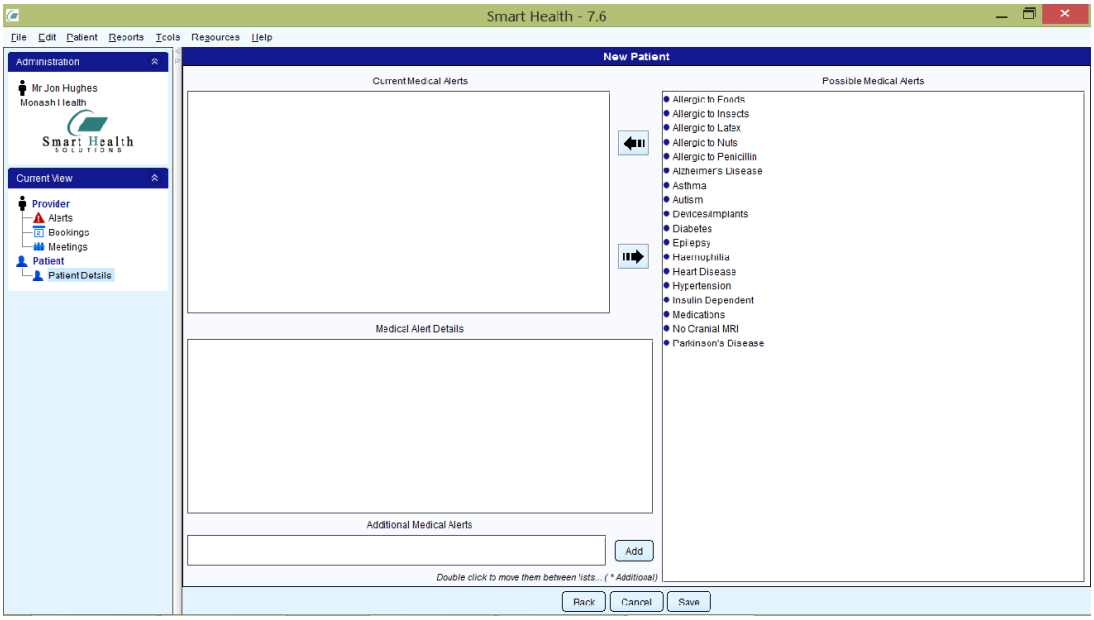
The Immunisation List tab in the right hand pane includes a Search function to find Immunisations:



Immunisations are saved as clinical event records.

When all immunisations have been entered, click Next.

8.2.9 Medical Alerts



Select Medical Alerts in the right hand pane and click the arrows between the panes to add them to, or remove them from the patient's profile. Additional Medical Alerts may be added by typing details in Additional Medical Alerts and clicking Add.

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When all Medical Alerts have been entered, click Save.

The new patient record will be saved and opened.

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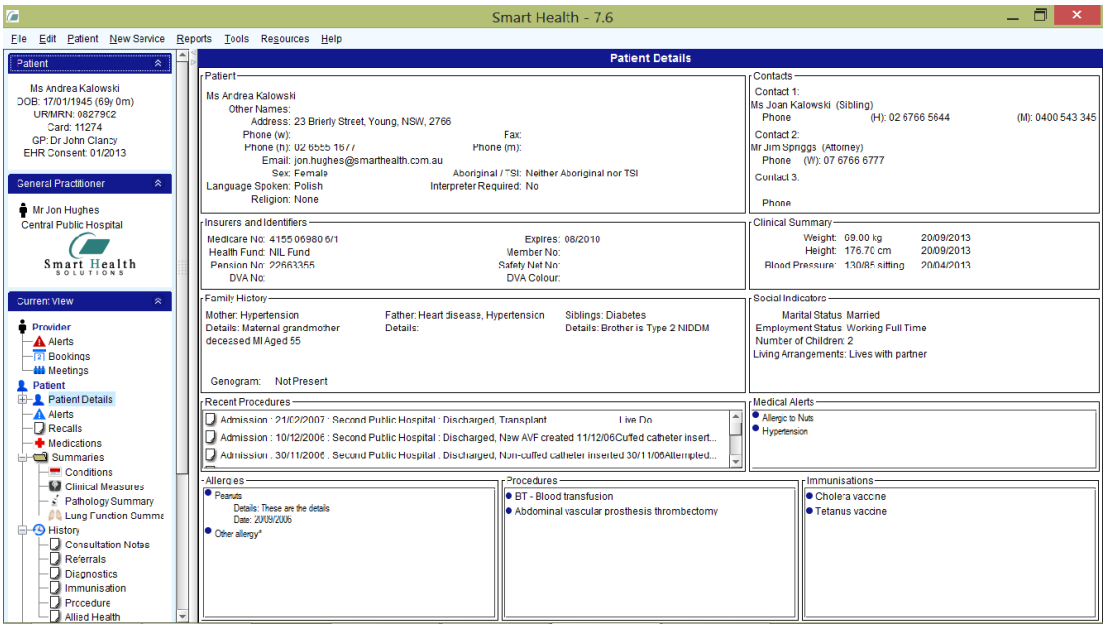
9. VIEWING THE PATIENT RECORD

The Navigation tree at the left of the screen is used to quickly move around the patient's health record. A single mouse click will open the selected part of the record.

The buttons in the main pane provide quick links to key components of the patient's health record.

9.1 Patient Details

Patient Details displays a summary of the major fixed elements of the patient record.



Each section of the Patient Details can be viewed in more detail by:

- Clicking the section name (group box name), which is a hyperlink to the detailed view, or
- Expanding the Patient Details view in the navigation tree by clicking the plus sign and then clicking the section name that you wish to view

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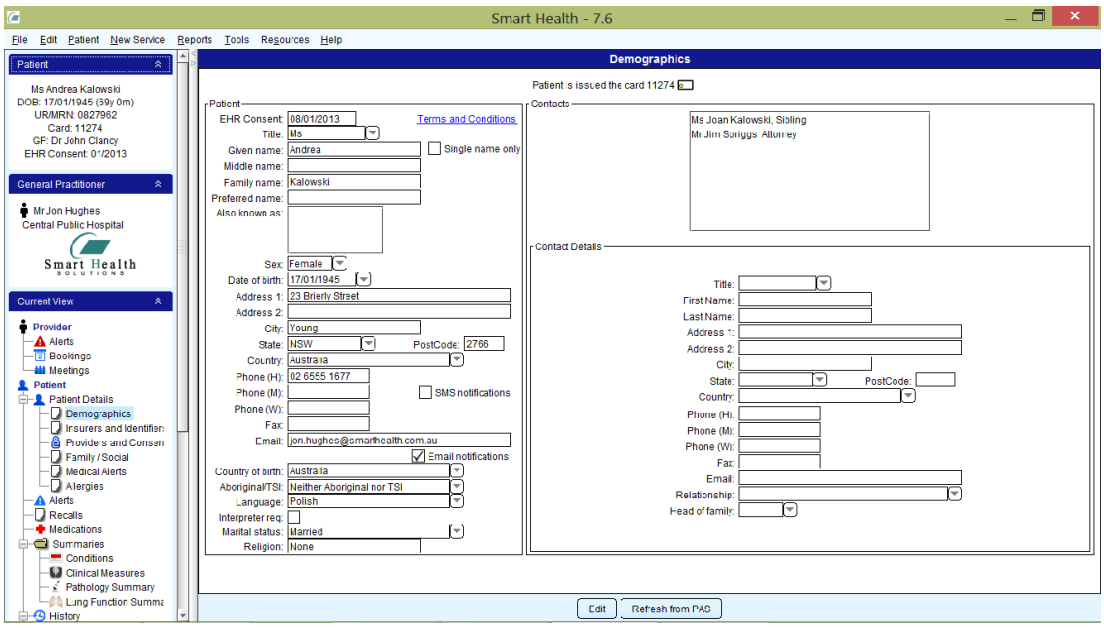
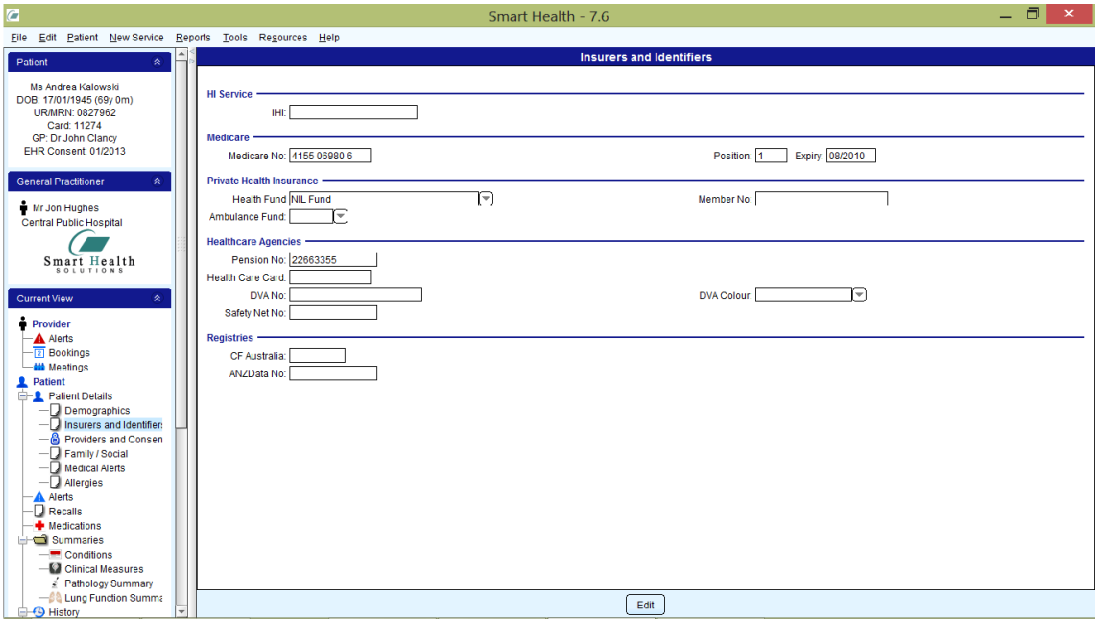
9.1.1 Patient/Contacts



Click a contact person's name to display his or her details.

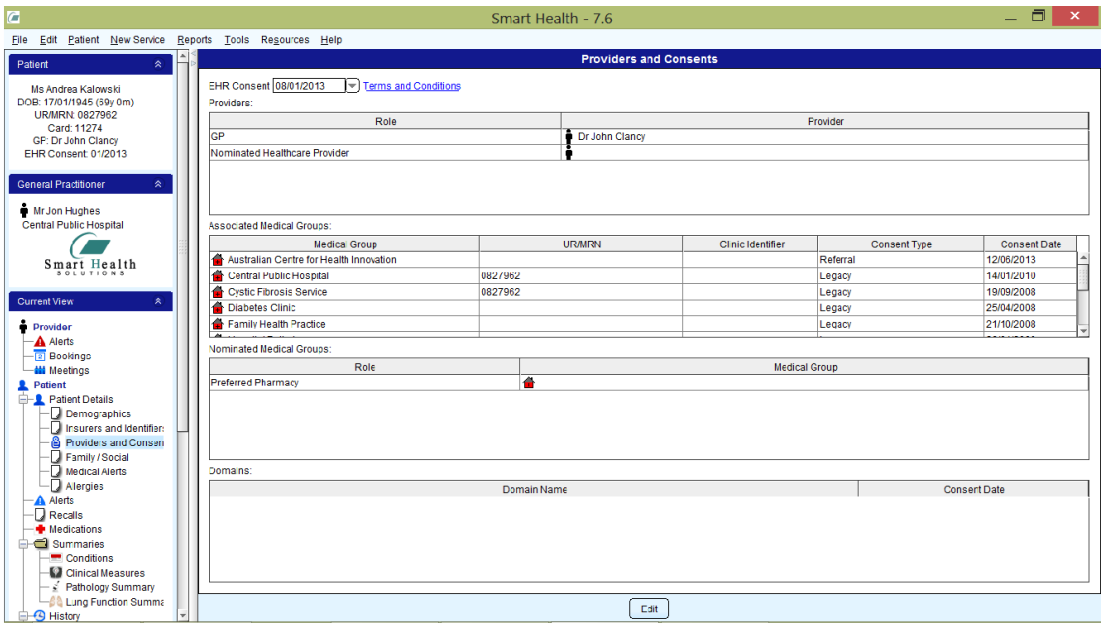
Click Edit to edit the patient details, including contact information.

9.1.2 Insurers and Identifiers



Click Edit to edit the patient's identifier and insurance details.

9.1.3 Providers and Consents



- The GP is the patient's usual general practitioner. Smart Health may send notifications/clinical documents to the GP automatically.
- The Nominated Healthcare Provider is the healthcare provider that the patient chooses to create Shared Health Summaries for the national PCEHR program.
- Associated Medical Groups are practices that have access to the patient's health records with the Smart Health shared health record repository. Smart Health maintains the patient's unique identifiers that are associated with these practices.
- Nominated Medical Groups are practices with whom the patient has a particular or special relationship, such as pharmacy for an elderly patient in an aged care facility.
- Domains are groups of healthcare practices that have agreed to collaborate to manage patient care, including the management of patient consent across the practices that are members of the Domain.

Click Edit to edit the patient's provider and consent details.

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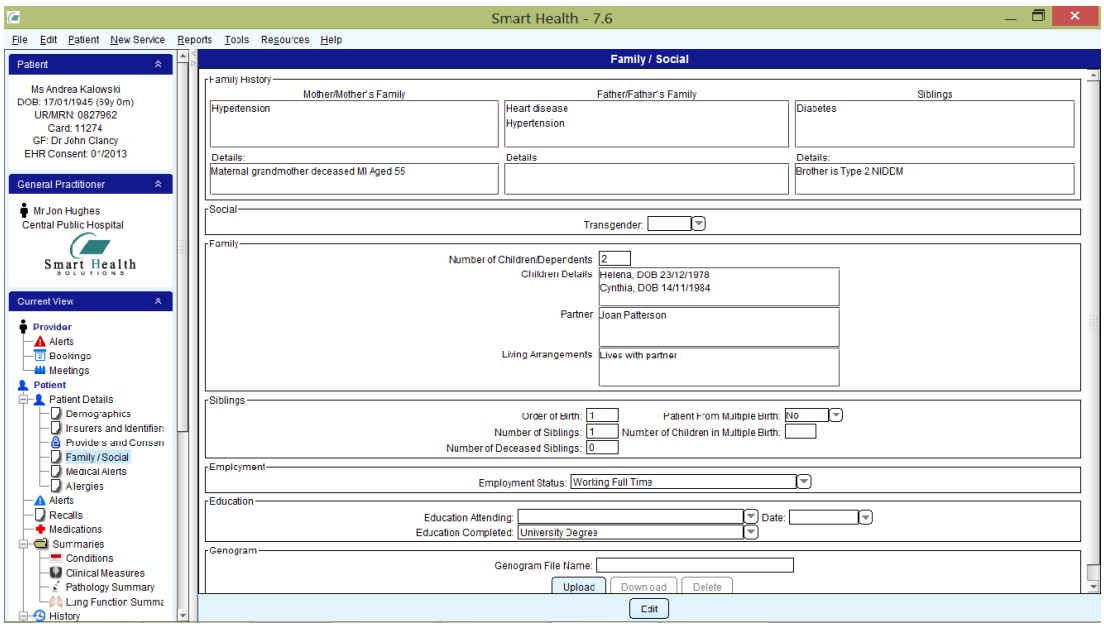
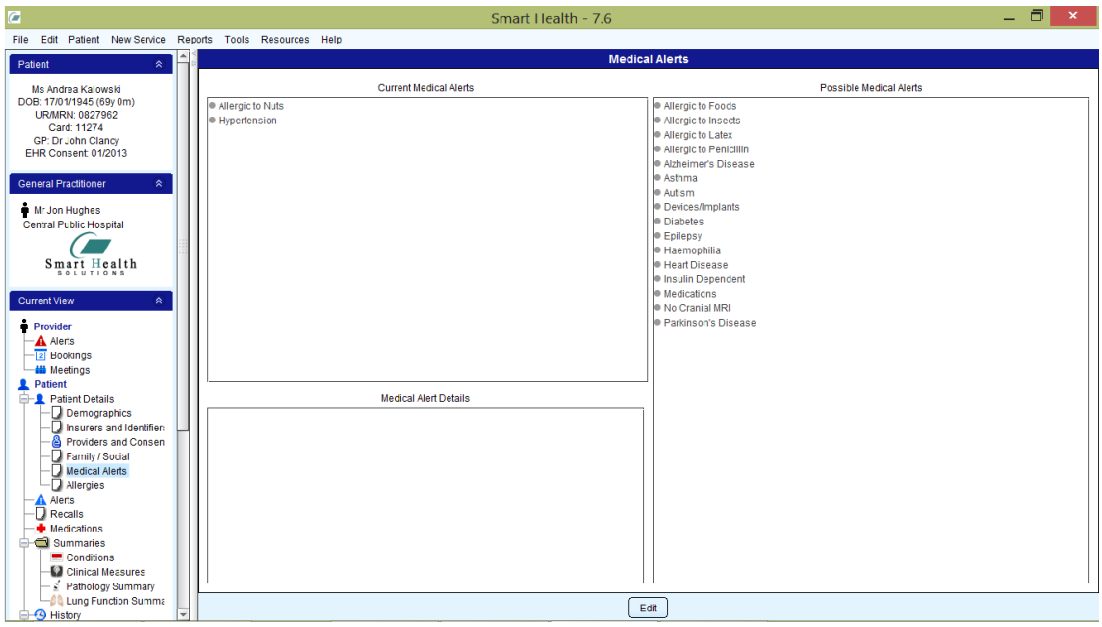
9.1.4 *Family/Social*



Click Edit to edit the patient's family and social details.

9.1.5 *Medical Alerts*



Click a medical alert to see the details for that alert.

Click Edit to edit the patient's medical alerts.

Select alerts to add to, or remove from the current alert list and click the arrows between the panels to update the lists. Add new alerts by typing the details in the bottom pane and clicking Add.

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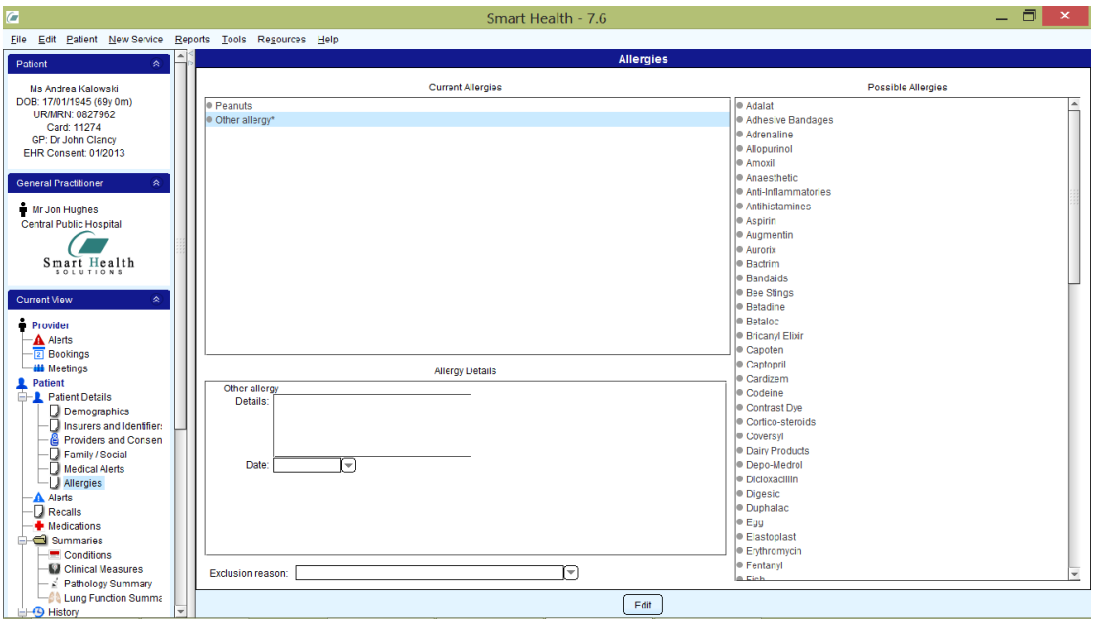
9.1.6 Allergies



Click an allergy to see the details for that allergy.

Click Edit to edit the patient's allergies.

Select allergies to add to, or remove from the current allergy list and click the arrows between the panels to update the lists. Add new allergies by typing the details in the bottom pane and clicking Add.

9.1.7 Immunisations

The immunisation section of the Patient Details displays a summary of the patient's immunisation records, which are recorded as healthcare events and stored in the patient's event history.

Selecting Immunisations from Patient Details switches the view to the patient's event history, filtered for Immunisation records only. More information on managing immunisations is provided later in this user guide.

9.1.8 Procedures

The procedures section of the Patient Details displays a summary of the patient's procedure records, which are recorded as healthcare events and stored in the patient's event history.

Selecting Procedures from Patient Details switches the view to the patient's event history, filtered for Procedure records only. More information on managing procedures is provided later in this user guide.

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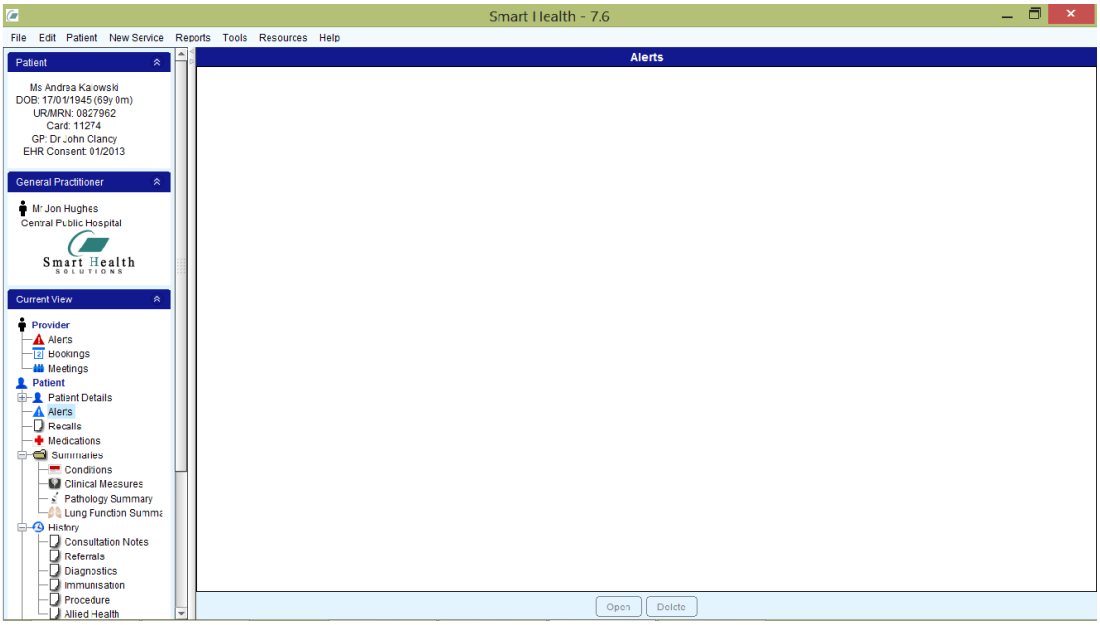
9.2 Alerts

The Alert view displays alerts that have been generated for this patient. Alerts are created when a patient is referred to you, when a patient recall is due and for various other clinical events.



The Alert view for the logged in user (Provider Alerts, in the Provider view above the Patient view), lists all Alerts for the user (not just those of the currently open patient).

9.3 Recalls

The Recall view displays Recalls that have been created for the patient whose record is open. Recalls are created by users as reminders for future healthcare events. When Recalls are due, Alerts are created for members of the medical group (practice) that created the recall. SMS and Email notifications may also be sent to providers and patients to remind them that the Recall is due.

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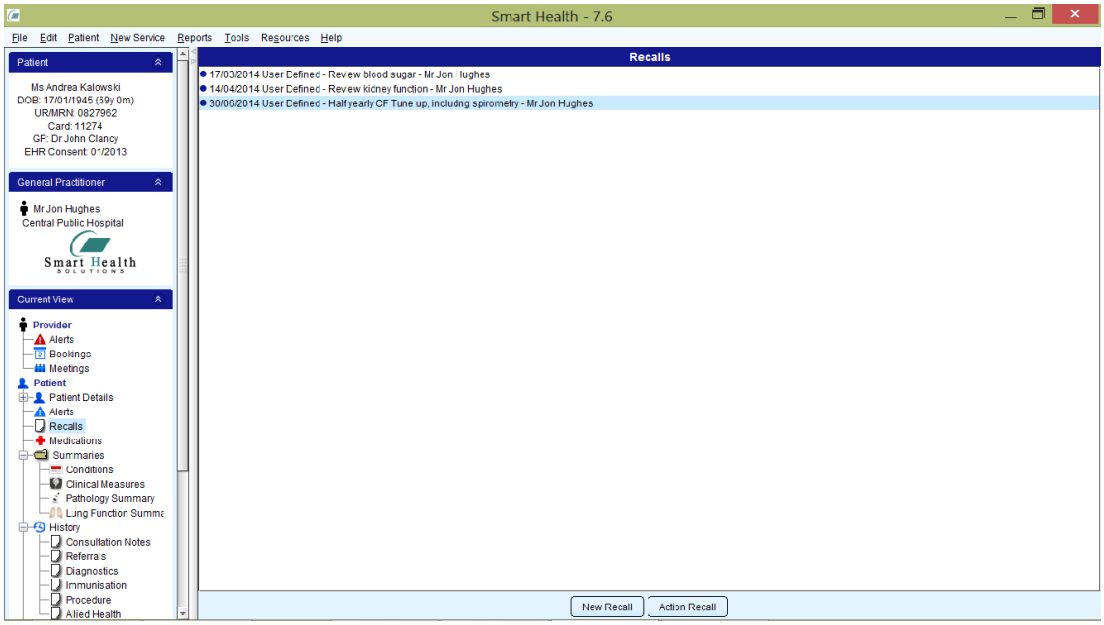
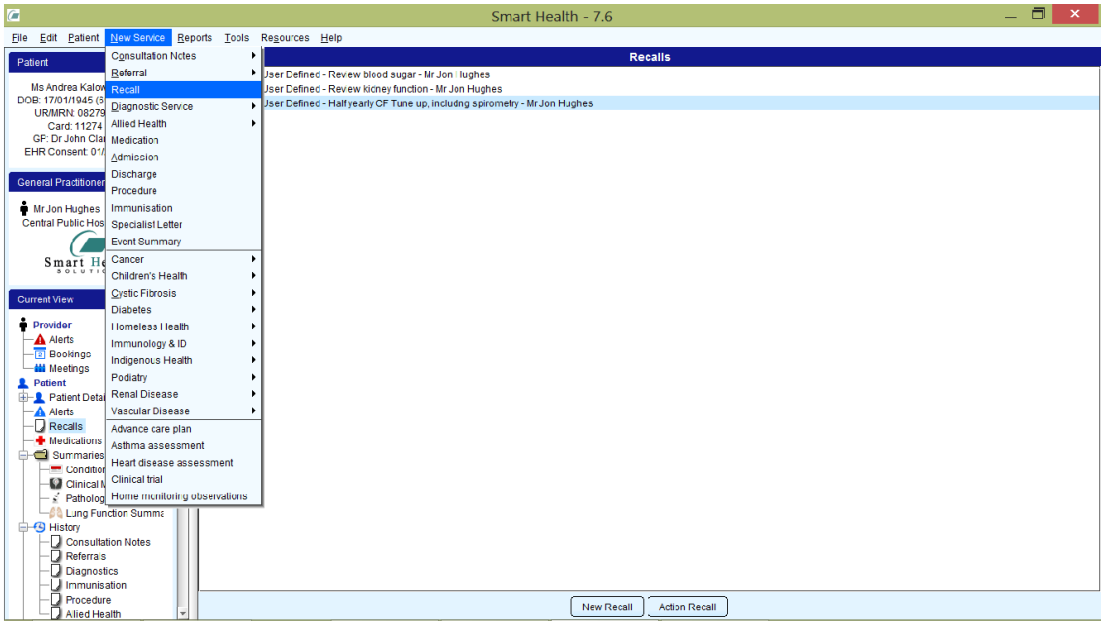
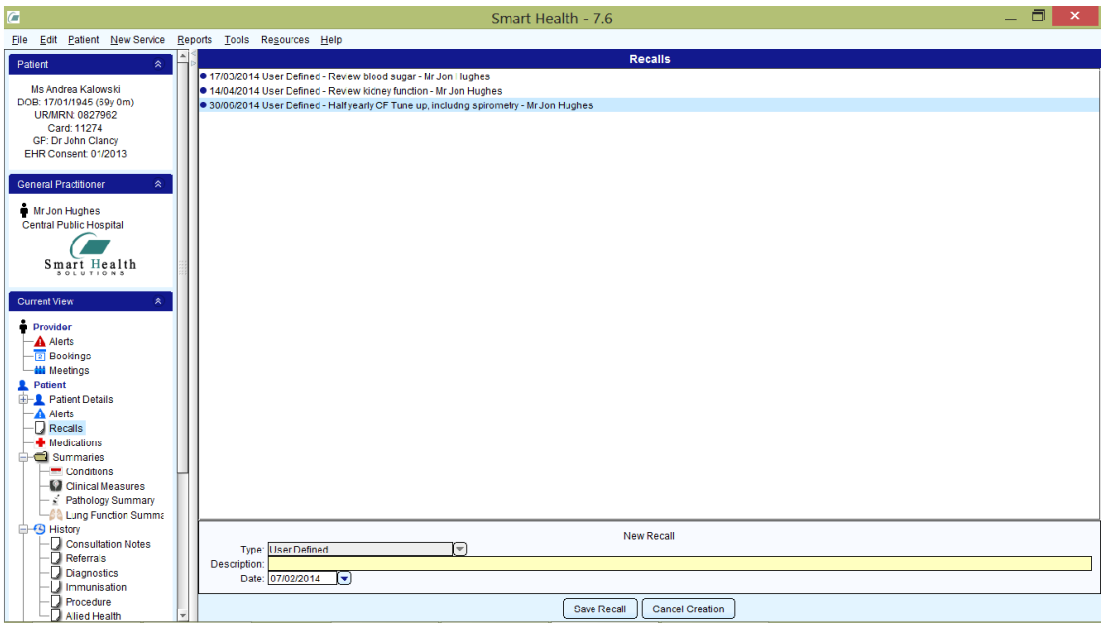


To create a new Recall, select Recall from the New Service menu:

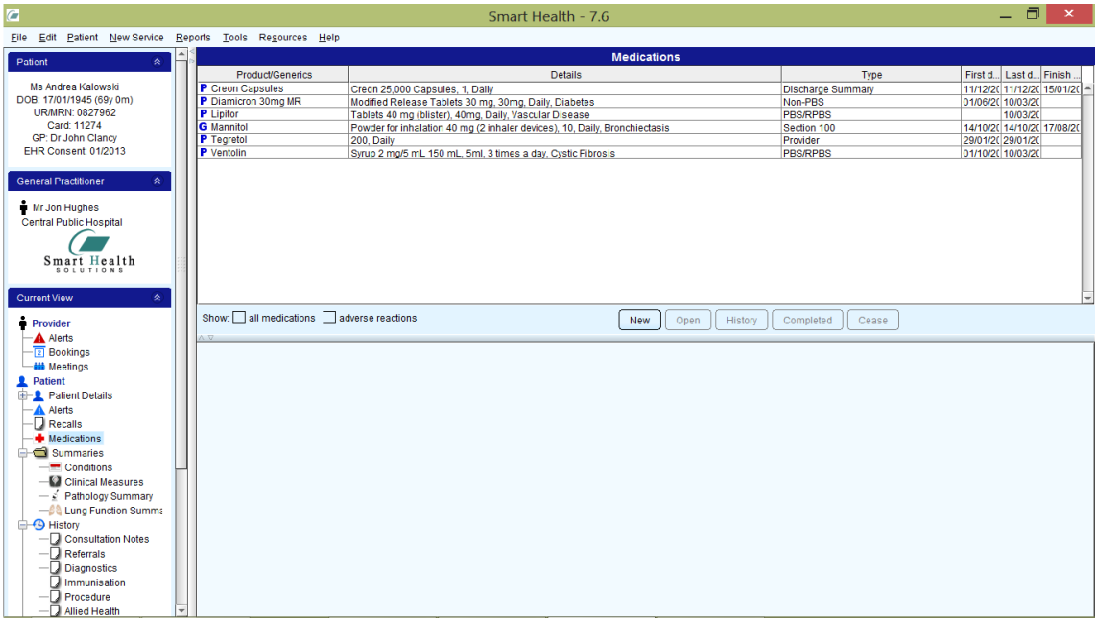


Complete the Recall details and click Save:

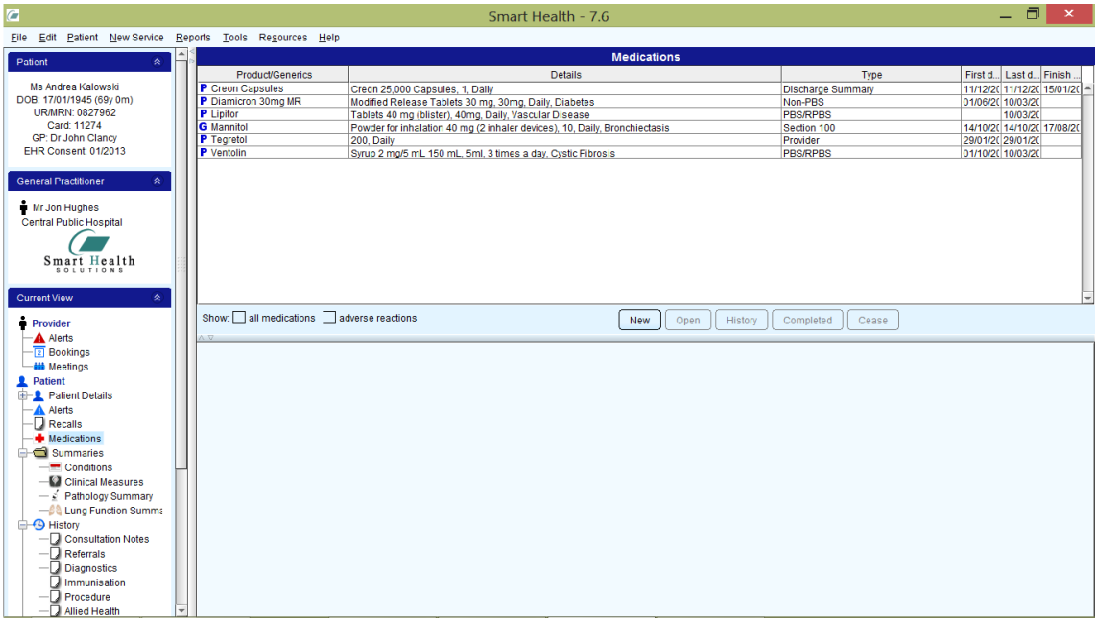


9.4 Medications

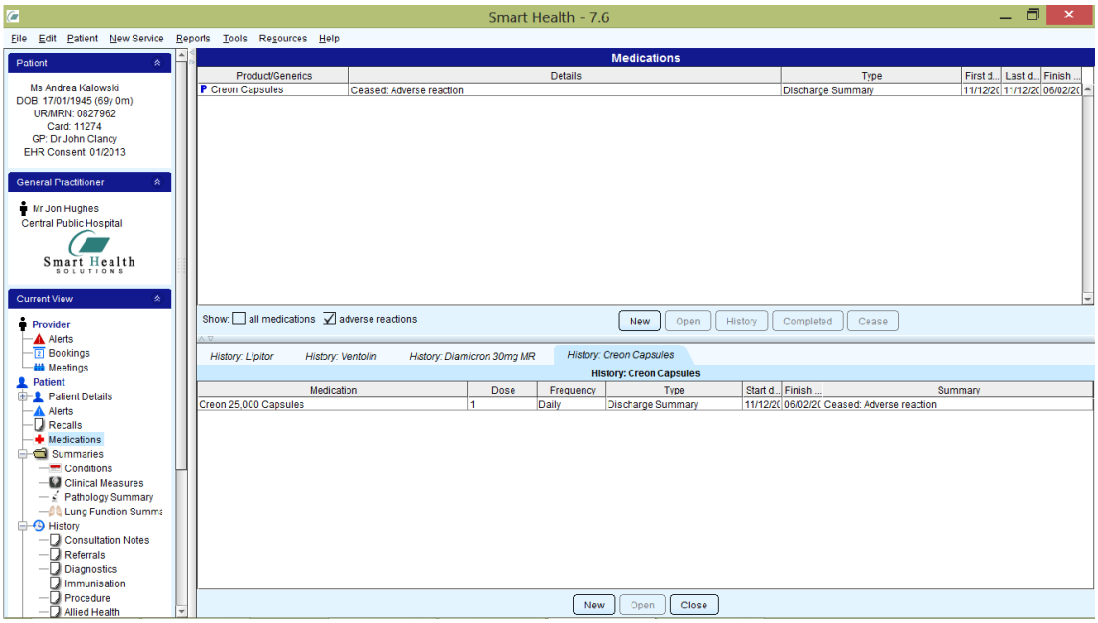
The Medications view displays the patient's current medications.



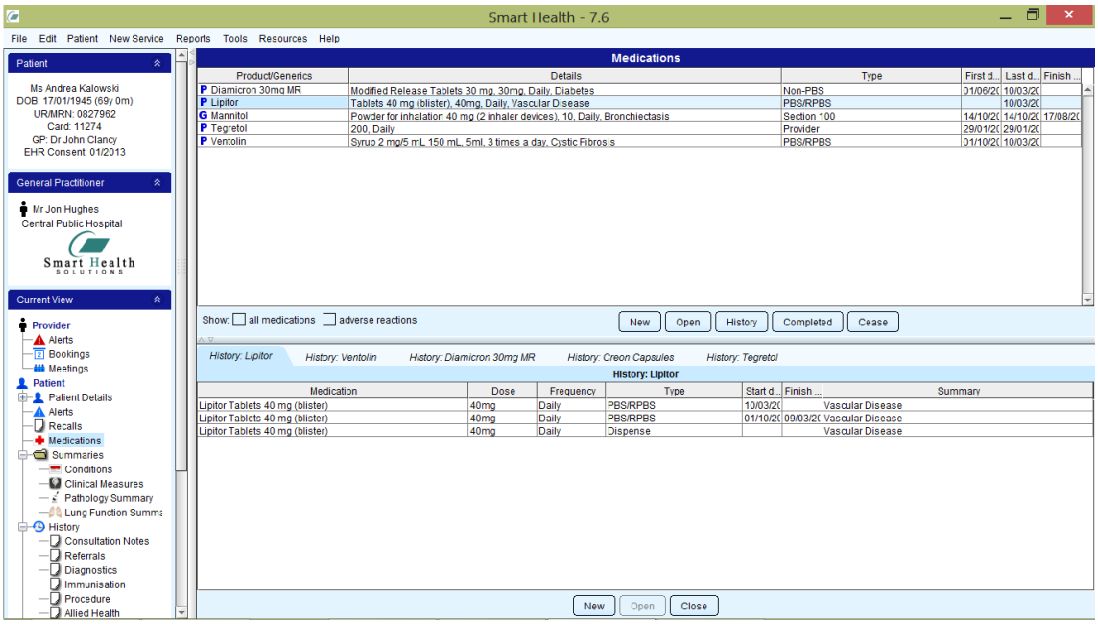
View all Medications (including historical Medications) by selecting the Show all medications check box:



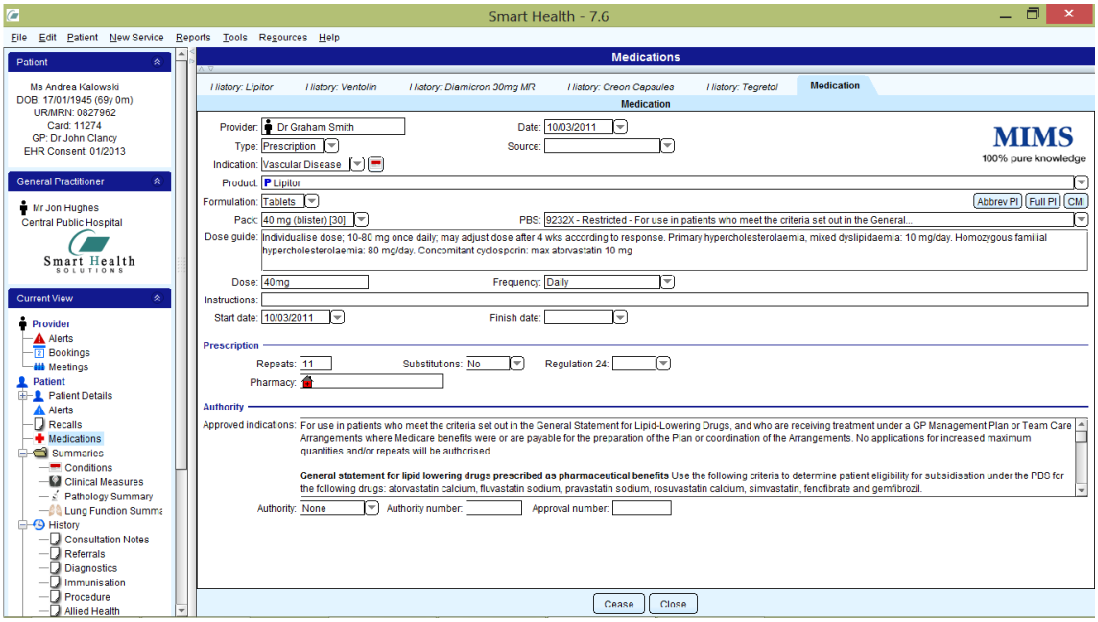
View Medications for which the patient has had adverse reactions by selecting the Show adverse reactions check box:



View the history for a medication by double-clicking the medication (anywhere in the medication row). The prescribing history is displayed in the lower pane:



Double click any specific instance of a medication to display the details in a separate tab:

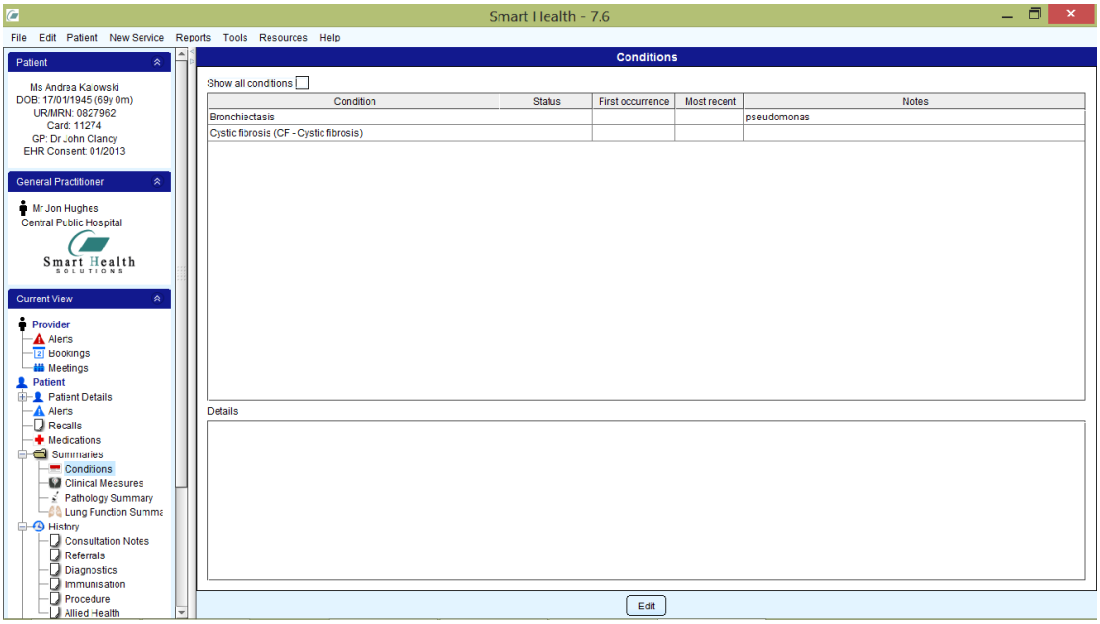

Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Medications
History: Lipitor
History: Ventolin
History: Diamicron 30mg MR
History: Creon Capsules
History: Tegretol
Medication
Medication
Provider: Dr Graham Smith
Date: 10/03/2011
Type: Prescription
Source:
Indication: Vascular Disease
Product: P Lipitor
Formulation: Tablets
Pack: 40 mg (blister) [30]
PBS: 9232X - Restricted - For use in patients who meet the criteria set out in the General...
Dose guide: Individualise dose; 10-80 mg once daily; may adjust dose after 4 wks according to response. Primary hypercholesterolaemia, mixed dyslipidaemia: 10 mg/day. Homozygous familial hypercholesterolaemia: 80 mg/day. Concomitant cyclosporin: max atorvastatin 10 mg
Dose: 40mg
Frequency: Daily
Instructions:
Start date: 10/03/2011
Finish date:
Prescription
Repeats: 11
Substitutions: No
Regulation 24:
Pharmacy:
Authority
Approved indications: For use in patients who meet the criteria set out in the General Statement for Lipid-Lowering Drugs, and who are receiving treatment under a GP Management Plan or Team Care Arrangements where Medicare benefits were or are payable for the preparation of the Plan or coordination of the Arrangements. No applications for increased maximum quantities and/or repeats will be authorised.
General statement for lipid lowering drugs prescribed as pharmaceutical benefits Use the following criteria to determine patient eligibility for substitution under the PBS for the following drugs: atorvastatin calcium, fluvastatin sodium, pravastatin sodium, rosuvastatin calcium, simvastatin, fenofibrate and gemfibrozil.
Authority: None
Authority number:
Approval number:
MIMS
100% pure knowledge
Abbrev PI
Full PI
CM
Cease
Close

More information on creating Medications, including Prescribing, is provided later in this Guide.

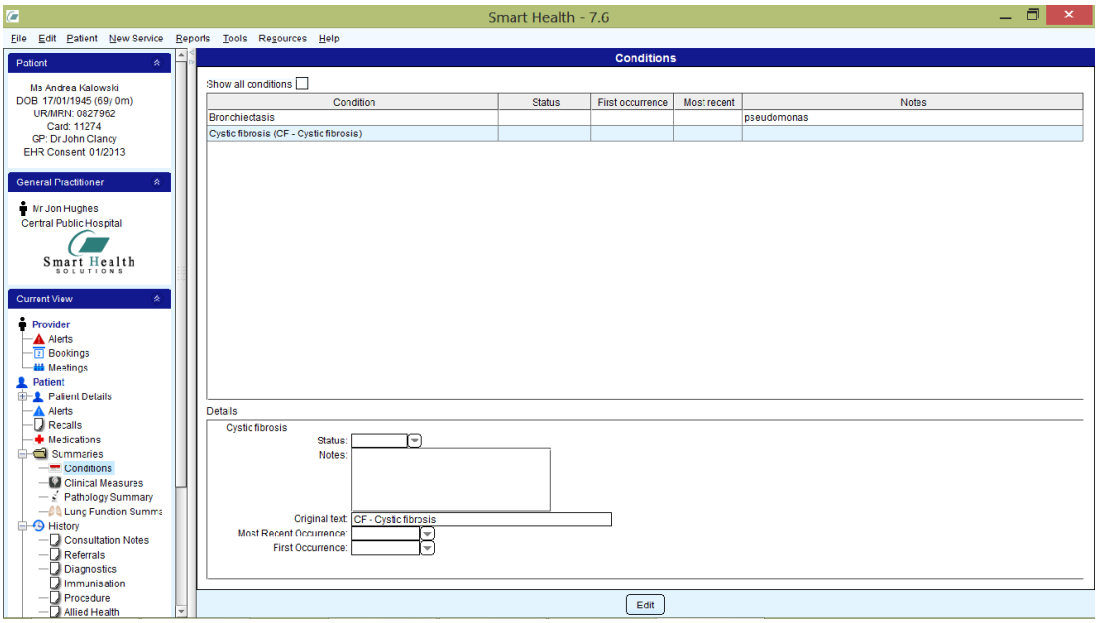
9.5 Summaries

Summary records present aggregated data in tabular form so that they can be easily viewed and monitored. These views are not designed for entering or editing data – they make it easier to quickly review large sets of clinical data (like pathology results) without having to select many clinical event records to do so.

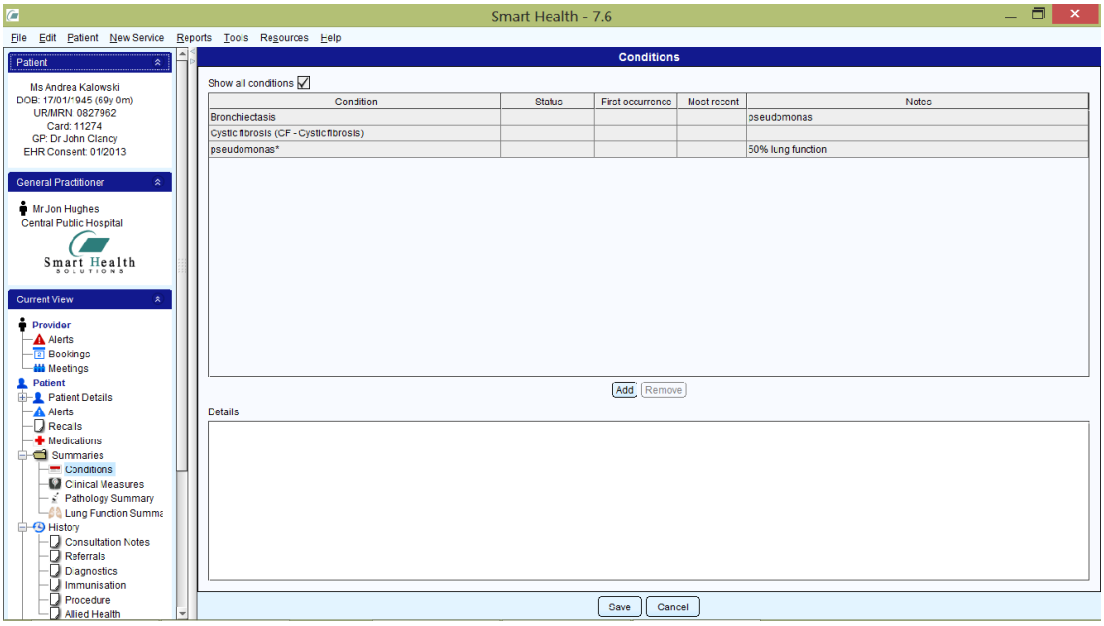
9.5.1 Conditions



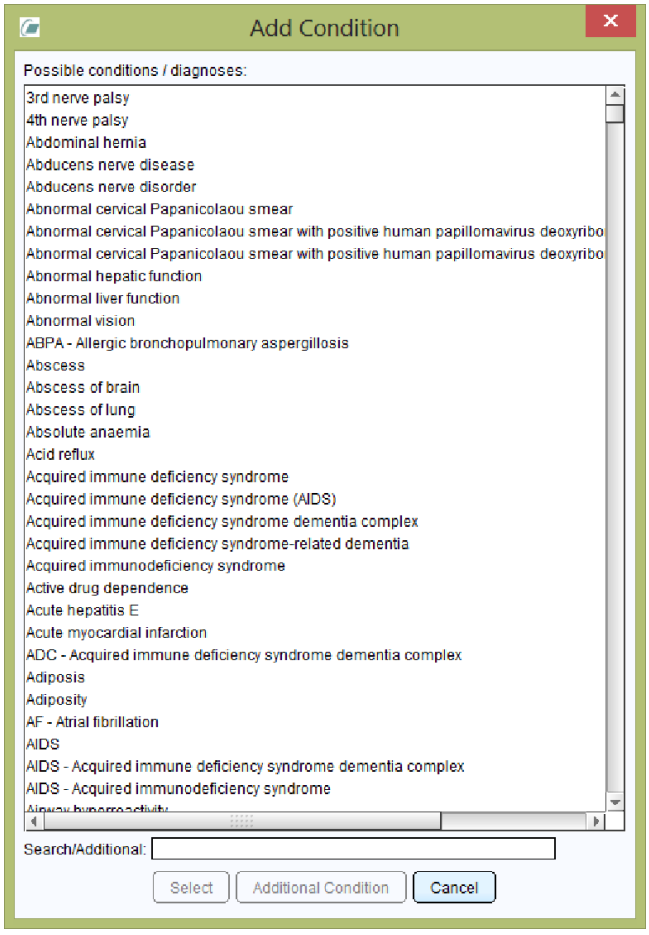
Select a condition from the list of conditions to display additional information in the lower panel:



Click Edit to update the patient's conditions.



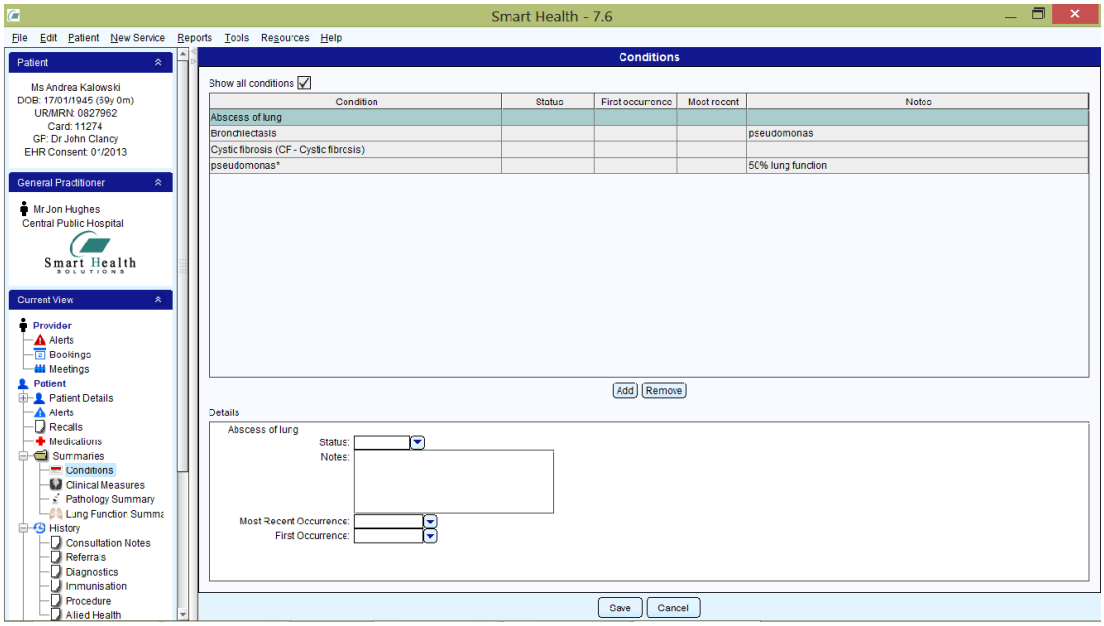
Click Add to select a new Condition:



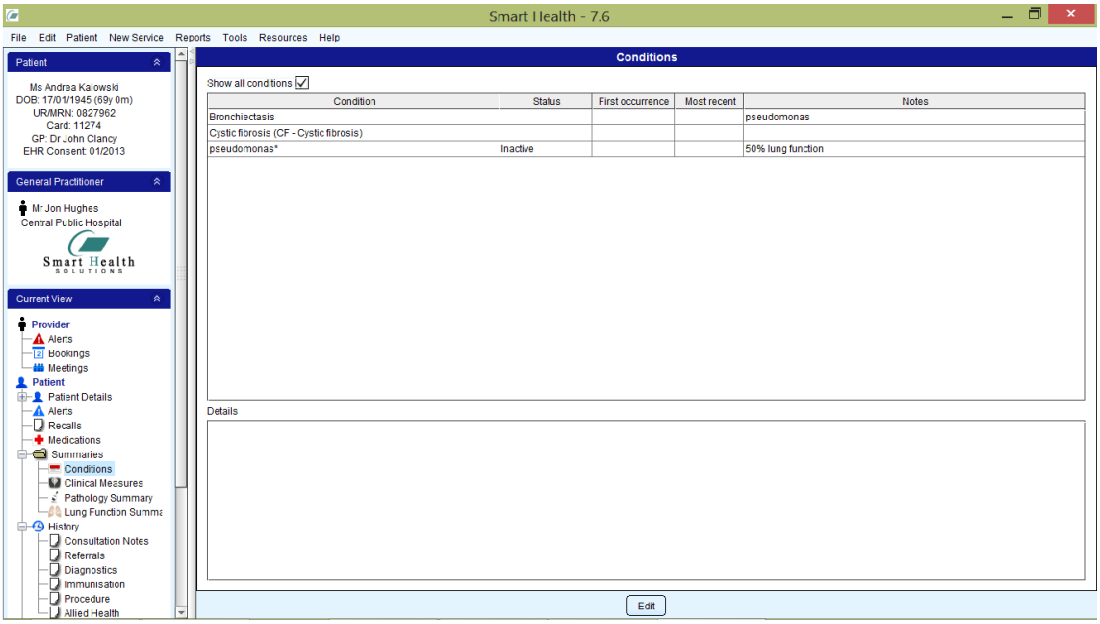
Type text in the Search/Additional field to select a Condition.

Select a Condition and click Select (or double click a Condition).

Enter additional details and click Save to save the Condition.

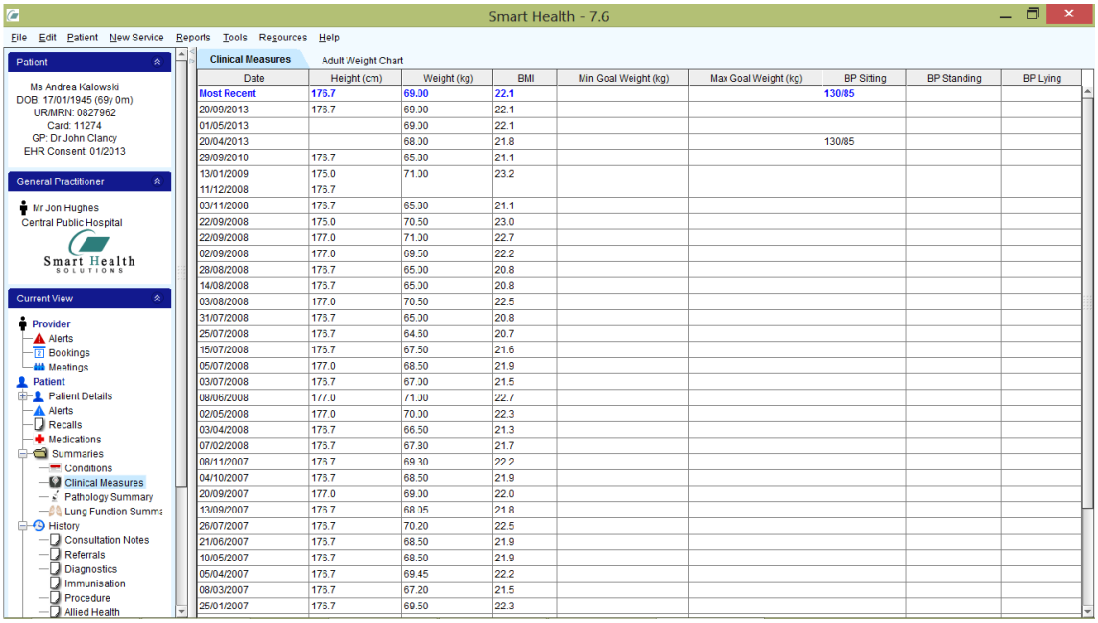


To display all conditions/diagnoses (including inactive conditions/diagnoses) select the Show All check box:

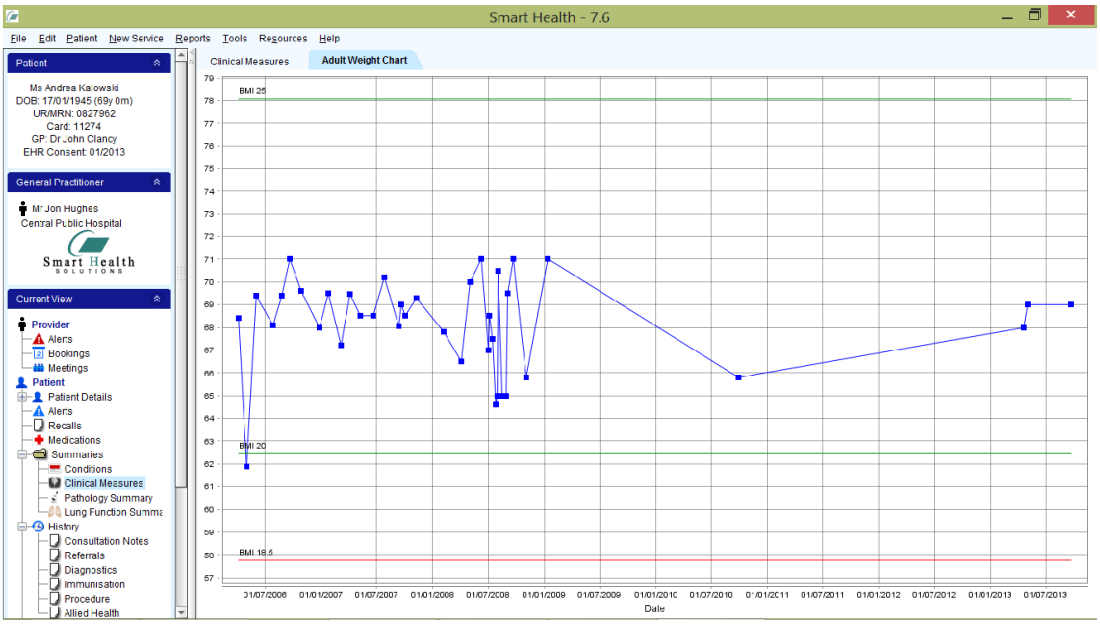


9.5.2 Clinical Measures

This view lists all of the patient's heights, weights and blood pressure measurements from the various Smart Health on-line forms where these measures may have been recorded.



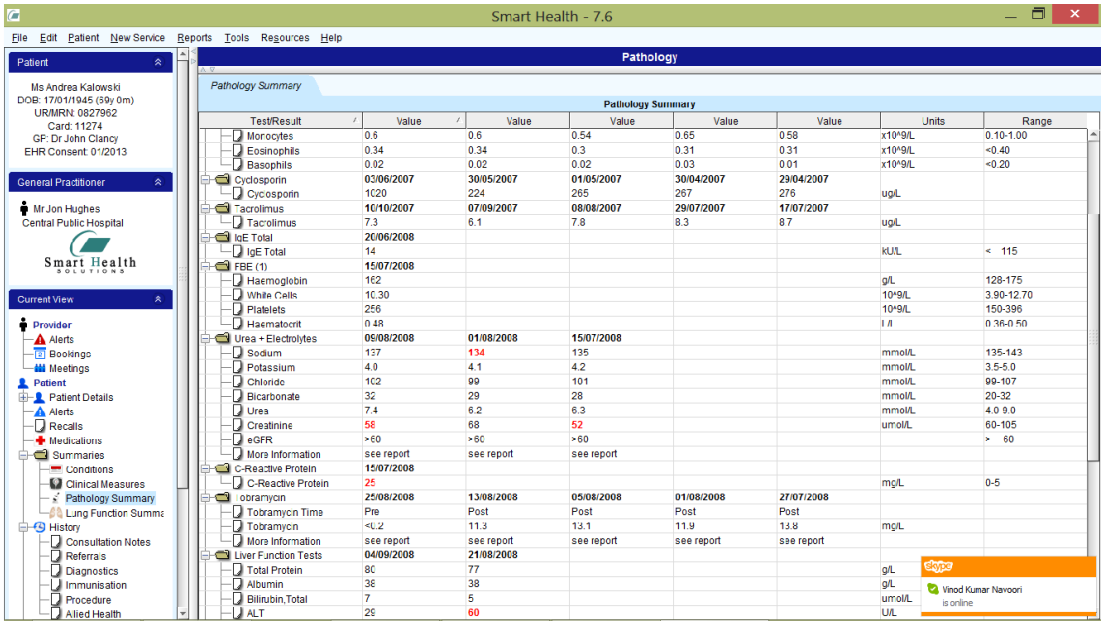
These measures are aggregated into a chronological view that provides a quick historical summary of each measure as well as a graph (in the second tab) of weight over time. If the patient is less than eighteen years old, the weight graph is displayed over a standard growth chart.



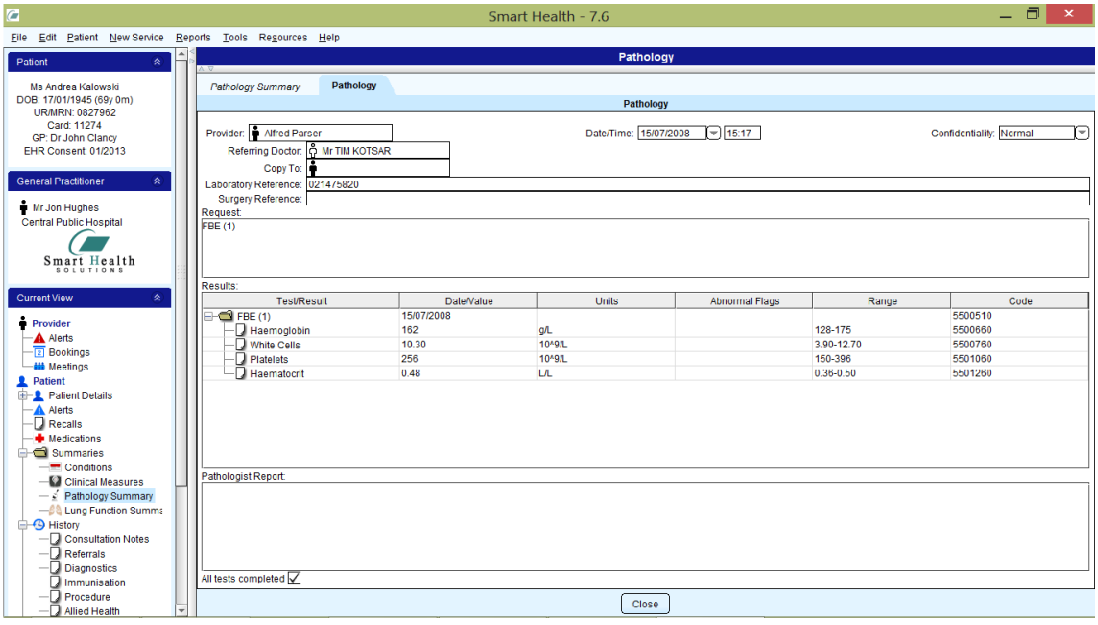
9.5.3 Pathology Summary

This view lists all of the patient's pathology results that have been imported into Smart Health. Smart Health supports the electronic importing of pathology results from most laboratory systems, including public and private pathology services. Abnormal results (as notified by the Laboratory) are highlighted in red.

Results are presented in chart form, with the most recent at the left and the oldest at the right.



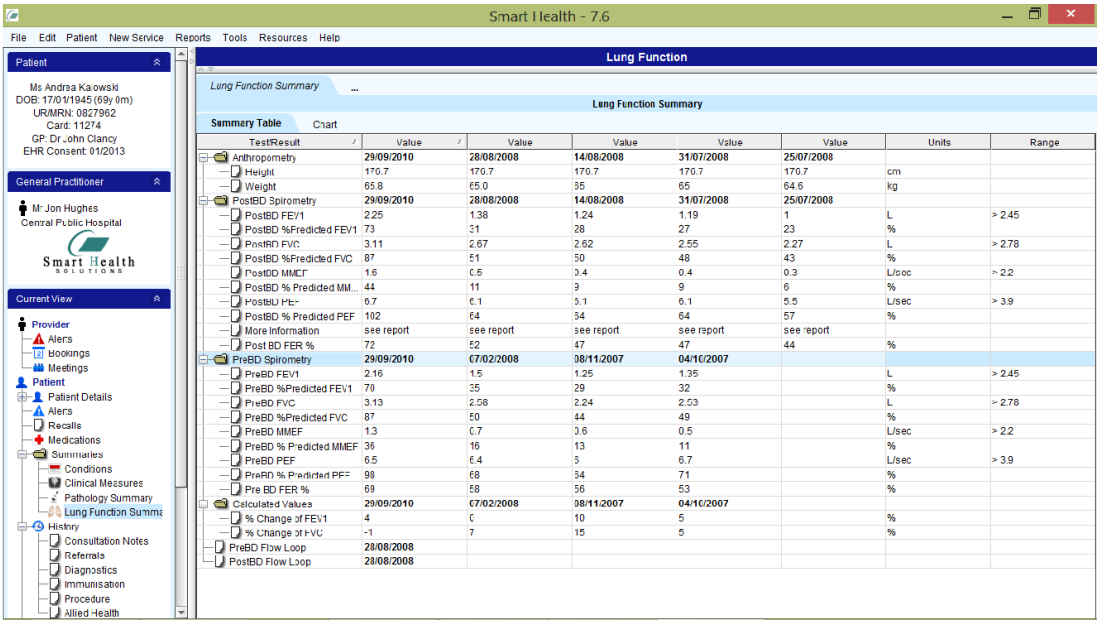
Users can select (double click) the date of a result to view the Pathology report in detail.



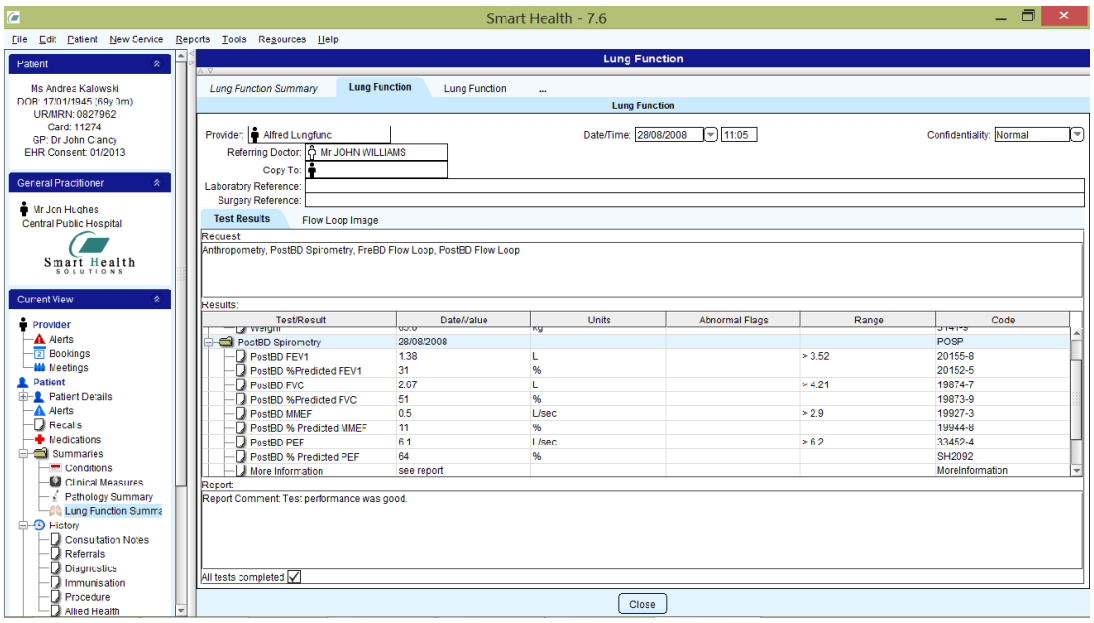
9.5.4 Lung Function Summary

This view lists all of the patient's lung function test results that have been imported into Smart Health. Smart Health supports the electronic importing of lung function results from several laboratory systems.

Results are presented in chart form, with the most recent at the left and the oldest at the right.

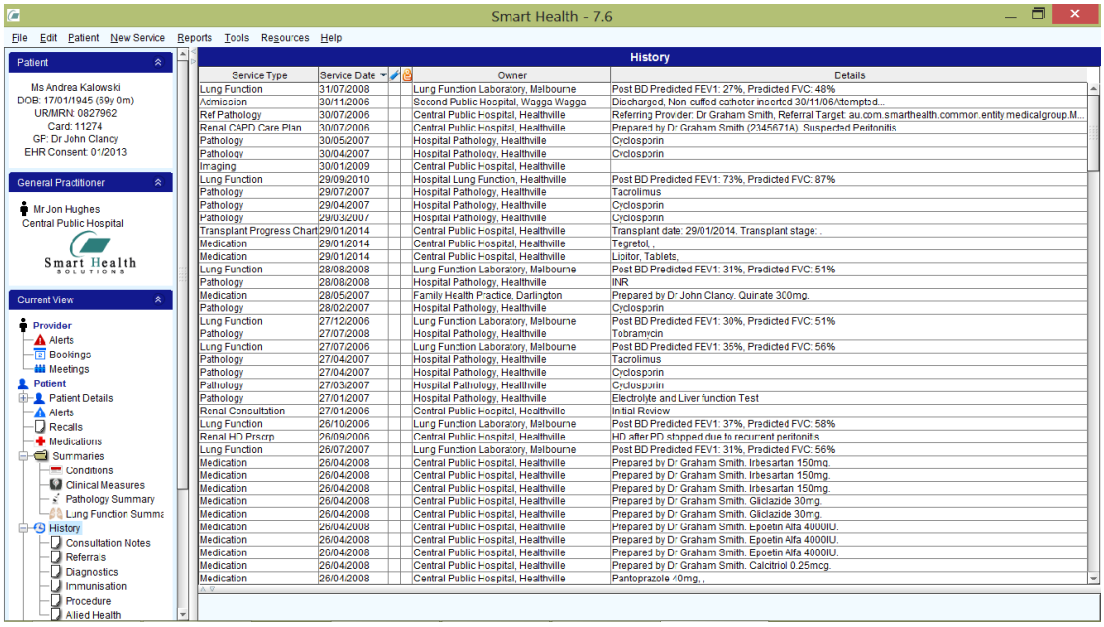

Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
General Practitioner
Mr Jon Hughes
Central Public Hospital
Smart Health
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Lung Function
Lung Function Summary
Lung Function Summary
Summary Table
Chart
Test/Result
Value
Value
Value
Value
Value
Units
Range
Anthropometry 29/09/2010 28/08/2008 14/08/2008 31/07/2008 25/07/2008
Height 170.7 170.7 170.7 170.7 170.7 cm
Weight 65.8 65.0 65 65 64.6 kg
PostBD Spirometry 29/09/2010 28/08/2008 14/08/2008 31/07/2008 25/07/2008
PostBD FEV1 2.25 1.38 1.24 1.19 1 L > 2.45
PostBD %Predicted FEV1 73 31 28 27 23 %
PostBD FVC 3.11 2.67 2.62 2.55 2.27 L > 2.78
PostBD %Predicted FVC 87 51 50 48 43 %
PostBD MMEF 1.6 0.5 0.4 0.4 0.3 L/sec > 2.2
PostBD % Predicted MM... 44 11 9 9 6 %
PostBD PEF 6.7 6.1 5.1 6.1 5.5 L/sec > 3.9
PostBD % Predicted PEF 102 64 54 64 57 %
More Information see report see report see report see report see report
Post BD FER % 72 52 47 47 44 %
PreBD Spirometry 29/09/2010 07/02/2008 08/11/2007 04/10/2007
PreBD FEV1 2.16 1.5 1.25 1.35 L > 2.45
PreBD %Predicted FEV1 70 35 29 32 %
PreBD FVC 3.13 2.08 2.24 2.03 L > 2.78
PreBD %Predicted FVC 87 50 44 49 %
PreBD MMEF 1.3 0.7 0.6 0.5 L/sec > 2.2
PreBD % Predicted MMEF 36 16 13 11 %
PreBD PEF 6.5 6.4 5 6.7 L/sec > 3.9
PreBD % Predicted PEF 98 68 54 71 %
Pre BD FER % 69 58 56 53 %
Calculated Values 29/09/2010 07/02/2008 08/11/2007 04/10/2007
% Change of FEV1 4 0 10 5 %
% Change of FVC -1 7 15 5 %
PreBD Flow Loop 28/08/2008
PostBD Flow Loop 28/08/2008

Users can select (double click) the date of a result to view the Lung Function report in detail:



9.6 History

The History view presents a list of every healthcare event that has been recorded for the patient. The list of event records is presented (by default) with the most recent records at the top (reverse chronological order).


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
General Practitioner
Mr Jon Hughes
Central Public Hospital
Smart Health
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
History
Service Type | Service Date | Owner | Details
Lung Function | 31/07/2008 | Lung Function Laboratory, Melbourne | Post BD Predicted FEV1: 27%, Predicted FVC: 48%
Admission | 30/11/2006 | Second Public Hospital, Wagga Wagga | Discharged, Non cuffed catheter inserted 30/11/06/tempted...
Ref Pathology | 30/07/2006 | Central Public Hospital, Healthville | Referring Provider: Dr Graham Smith, Referral Target: au.com.smarthealth.commor.entity.medicalgroup.M...
Renal CAPD Care Plan | 30/07/2006 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith (2145671A). Suspected Peritonitis
Pathology | 30/05/2007 | Hospital Pathology, Healthville | Cyclosporin
Pathology | 30/04/2007 | Hospital Pathology, Healthville | Cyclosporin
Imaging | 30/01/2009 | Central Public Hospital, Healthville
Lung Function | 29/09/2010 | Hospital Lung Function, Healthville | Post BD Predicted FEV1: 73%, Predicted FVC: 87%
Pathology | 29/07/2007 | Hospital Pathology, Healthville | Tacrolimus
Pathology | 29/04/2007 | Hospital Pathology, Healthville | Cyclosporin
Pathology | 29/03/2007 | Hospital Pathology, Healthville | Cyclosporin
Transplant Progress Chart | 29/01/2014 | Central Public Hospital, Healthville | Transplant date: 29/01/2014. Transplant stage: .
Medication | 29/01/2014 | Central Public Hospital, Healthville | Tegretol, .
Medication | 29/01/2014 | Central Public Hospital, Healthville | Lipitor, Tablets,
Lung Function | 28/08/2008 | Lung Function Laboratory, Melbourne | Post BD Predicted FEV1: 31%, Predicted FVC: 51%
Pathology | 28/08/2008 | Hospital Pathology, Healthville | INR
Medication | 28/05/2007 | Family Health Practice, Darlington | Prepared by Dr John Clancy. Quirate 300mg.
Pathology | 28/02/2007 | Hospital Pathology, Healthville | Cyclosporin
Lung Function | 27/12/2006 | Lung Function Laboratory, Melbourne | Post BD Predicted FEV1: 30%, Predicted FVC: 51%
Pathology | 27/07/2008 | Hospital Pathology, Healthville | Tobramycin
Lung Function | 27/07/2006 | Lung Function Laboratory, Melbourne | Post BD Predicted FEV1: 35%, Predicted FVC: 56%
Pathology | 27/04/2007 | Hospital Pathology, Healthville | Tacrolimus
Pathology | 27/04/2007 | Hospital Pathology, Healthville | Cyclosporin
Pathology | 27/03/2007 | Hospital Pathology, Healthville | Cyclosporin
Pathology | 27/01/2007 | Hospital Pathology, Healthville | Electrolyte and Liver function Test
Renal Consultation | 27/01/2006 | Central Public Hospital, Healthville | Initial Review
Lung Function | 26/10/2006 | Lung Function Laboratory, Melbourne | Post BD Predicted FEV1: 37%, Predicted FVC: 58%
Renal HD Prscrp | 26/09/2006 | Central Public Hospital, Healthville | HD after PD stopped due to recurrent peritonitis
Lung Function | 26/07/2007 | Lung Function Laboratory, Melbourne | Post BD Predicted FEV1: 31%, Predicted FVC: 56%
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Irbesartan 150mg.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Irbesartan 150mg.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Irbesartan 150mg.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Gliclazide 30mg.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Gliclazide 30mg.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Epoetin Alfa 4000IU.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Epoetin Alfa 4000IU.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Epoetin Alfa 4000IU.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Prepared by Dr Graham Smith. Calcitriol 0.25mcg.
Medication | 26/04/2008 | Central Public Hospital, Healthville | Pantoprazole 40mg, .

The service record history can be sorted (and reverse sorted) by Service Type, Service Date, Owner and Details. Simply click the column heading to sort the table by that column's data and click the column heading again to reverse the sort order for that column.

To view specific service record types, click the navigation tree filter names below History to limit the History view to particular types of records, such as Consultation Notes:

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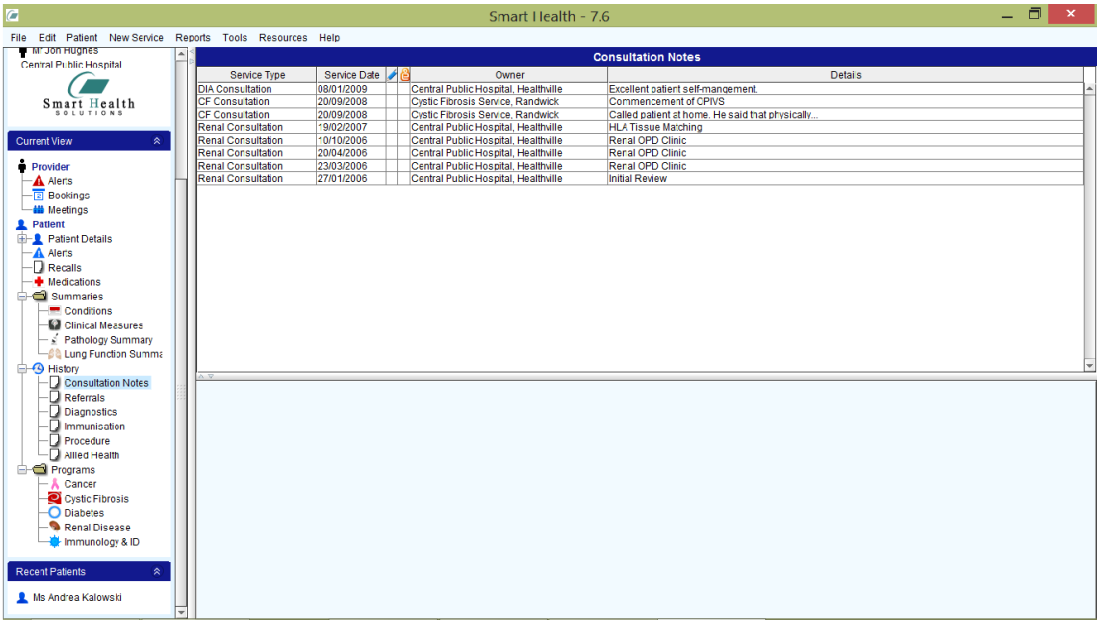
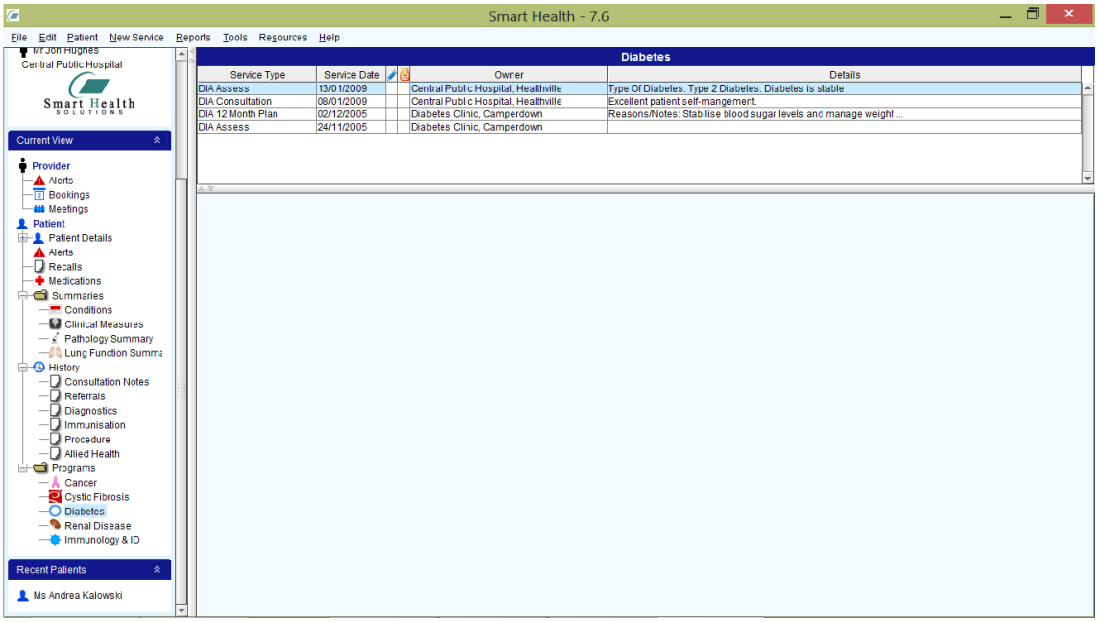


9.7 Programs

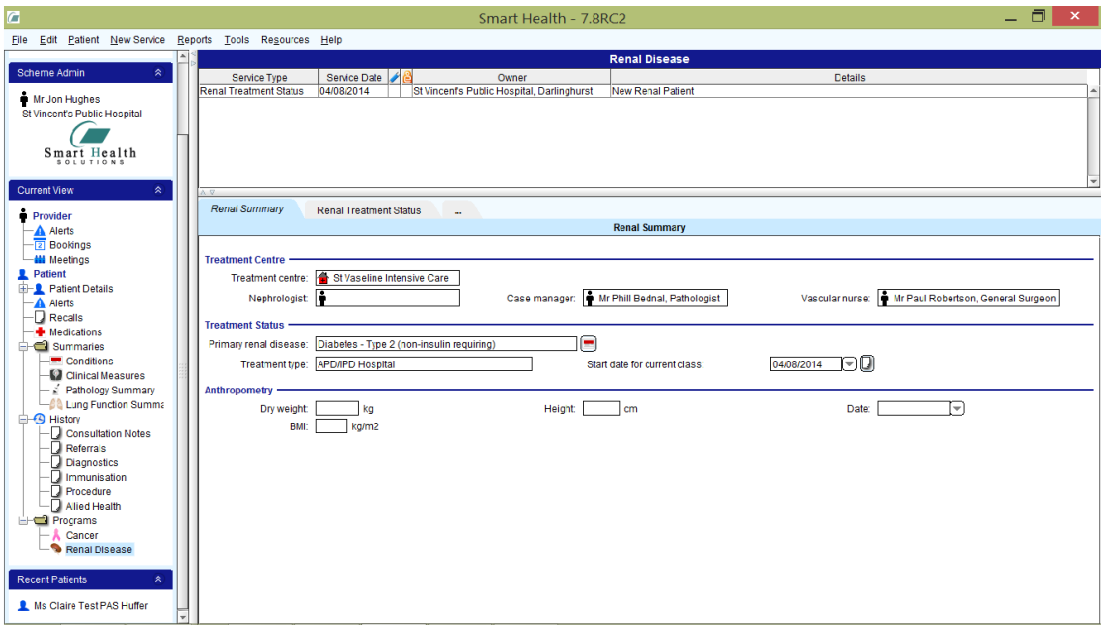
Managed health programs consist of specific health event records that are associated with particular disease or other health management programs.

Clicking the service record program filters (below Programs) filters the History view to particular managed health program records:

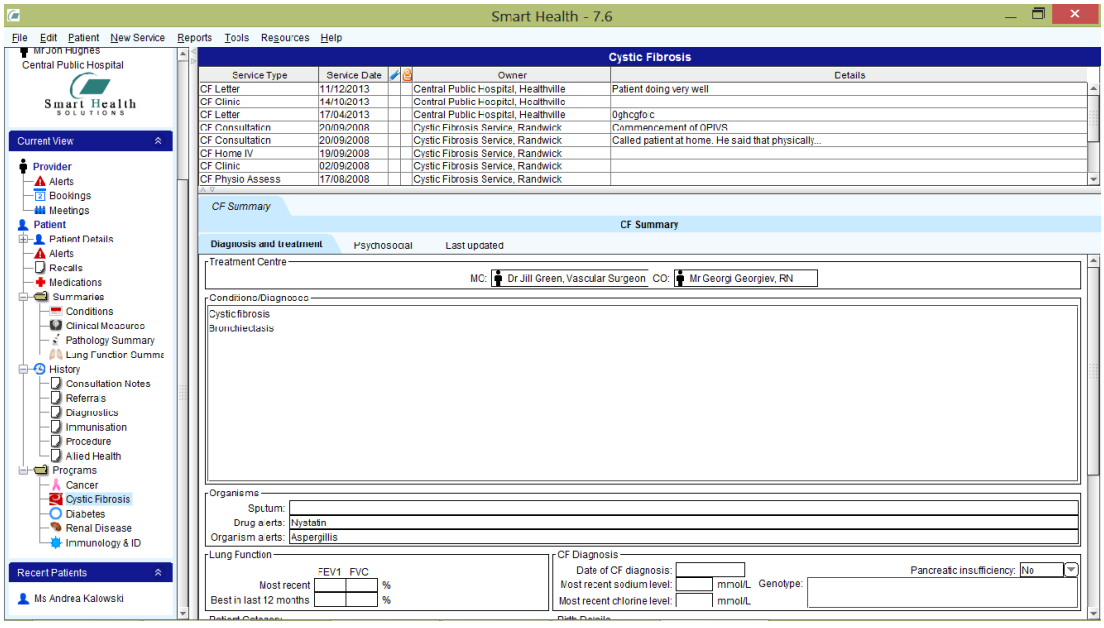


Some Program views include read-only summaries of core clinical data ("Front Page").

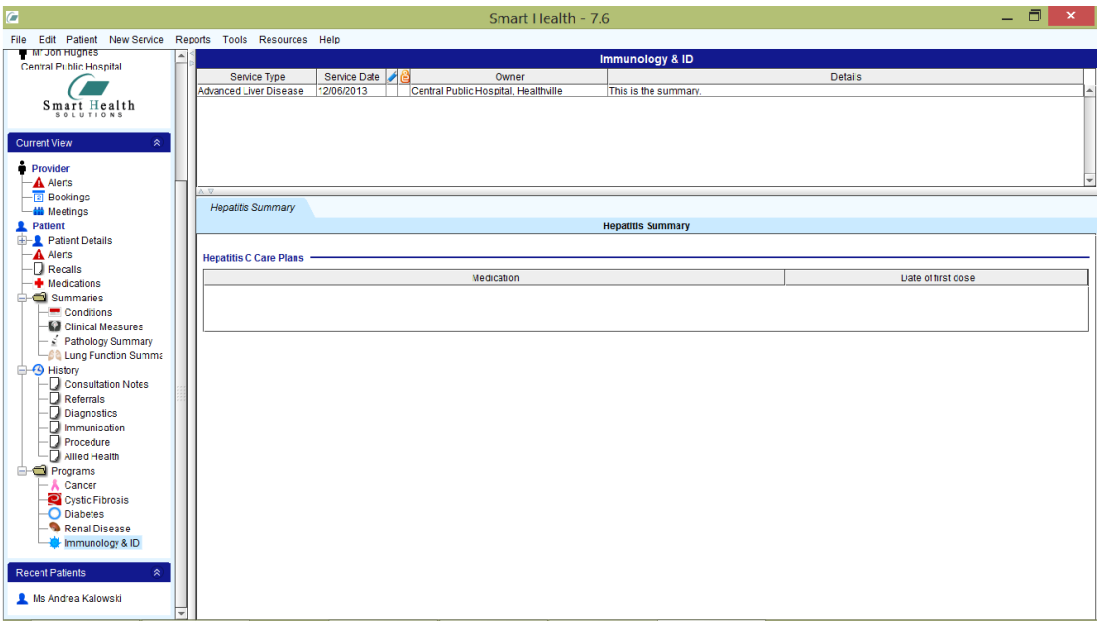
Renal Disease View, including read-only Summary



Cystic Fibrosis View, including read-only Summary

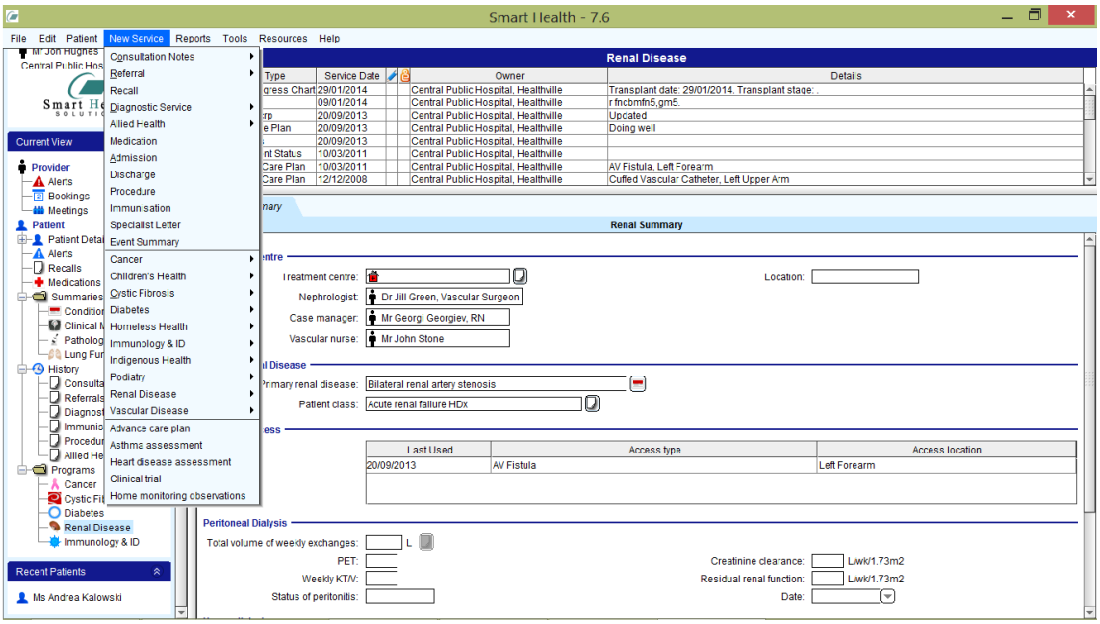


Immunology and Infectious Diseases View, including read-only Summary

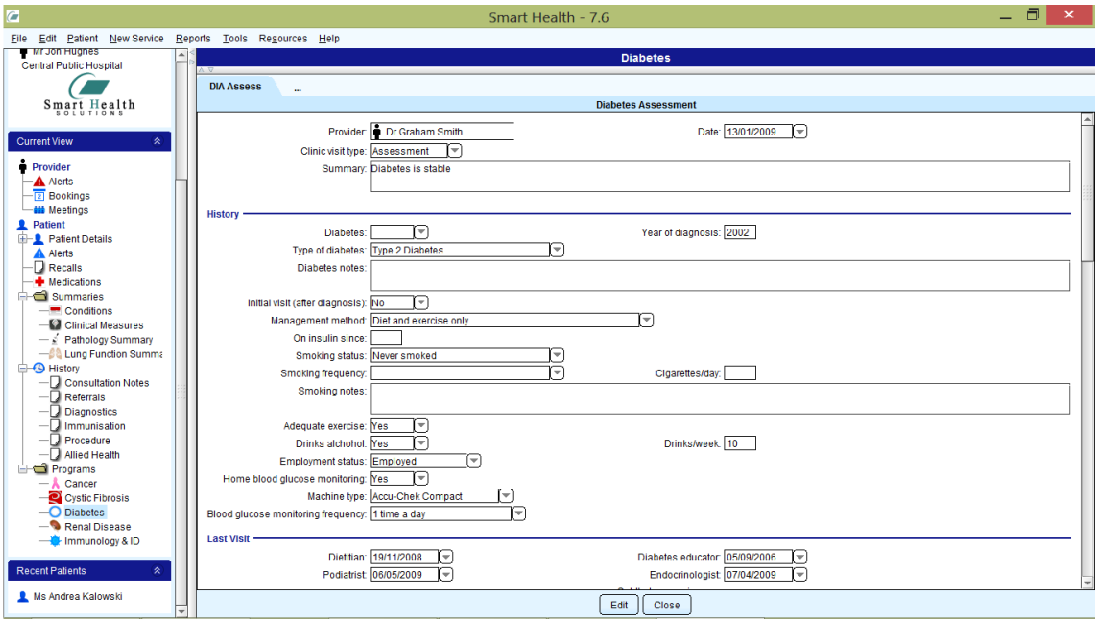


10. CLINICAL EVENT RECORDS

Create new clinical event records by selecting them from the New Service menu:



Edit existing clinical event records by double clicking them in the Service Record History and then clicking the Edit button (an Edit button is not displayed if the service record is not editable or if you do not have permission to edit the record).



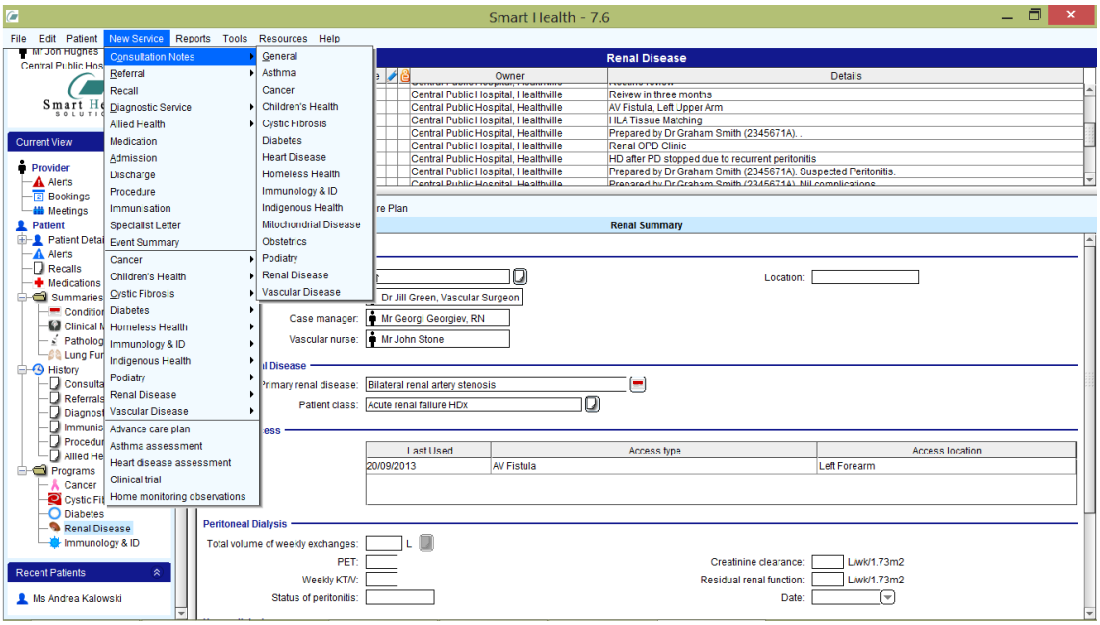
10.1 Consultation

Consultation Note forms are created to record text based notes from a patient consultation (or telephone conversation, email or other patient interaction). Consultation Notes record some structured data, including patient height, weight and blood pressure in addition to text notes.

If a Consultation Note is created for a specific disease or health management program, the Note will appear in the filtered view for that disease or health management program.

A General Consultation Note only appears in the main History and Consultations views.

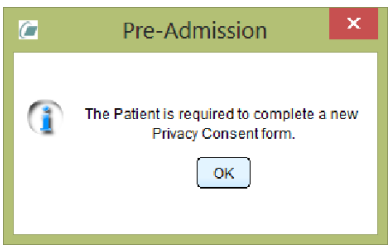
Some Consultation Notes may not be editable once they have been saved.



10.2 Admission

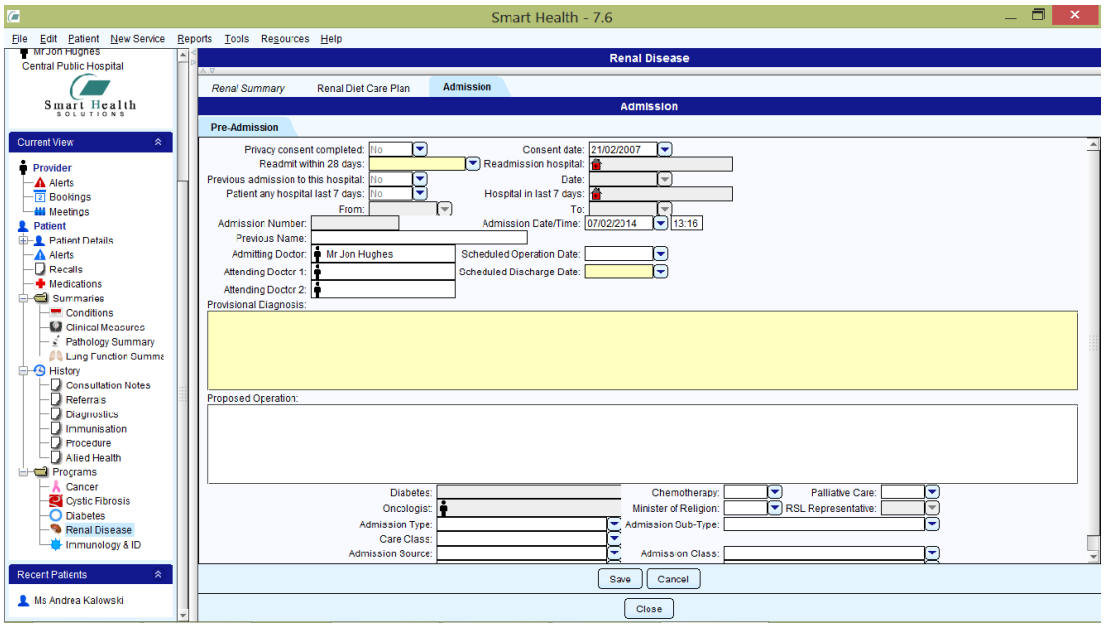
10.2.1 Pre-Admission

Admission records are created to capture hospital pre-admission, admission and discharge details for a patient. If the patient does not have a current Privacy Consent form for the Admitting practice, an Alert is displayed:



Click OK to clear the alert.

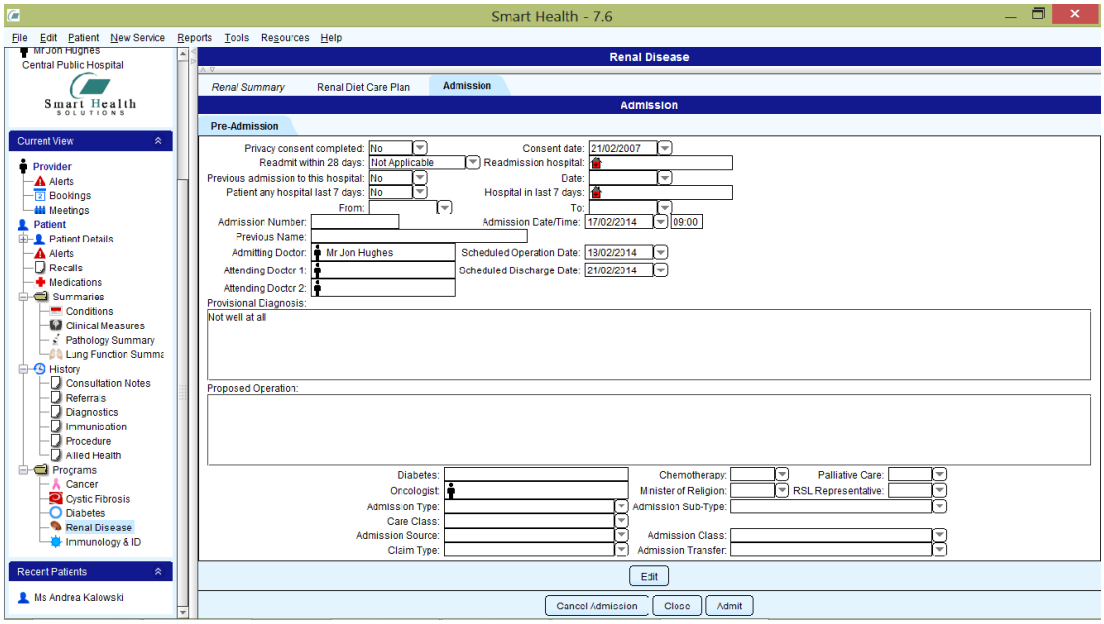
When creating a new Admission record, the user is first prompted to create a Pre-Admission:



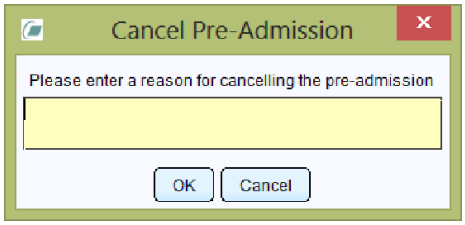
Complete all mandatory fields and click Save to save the record.

10.2.2 Cancel Pre-Admission

A Pre-Admission can be cancelled by opening the Pre-Admission record and clicking Cancel Admission:



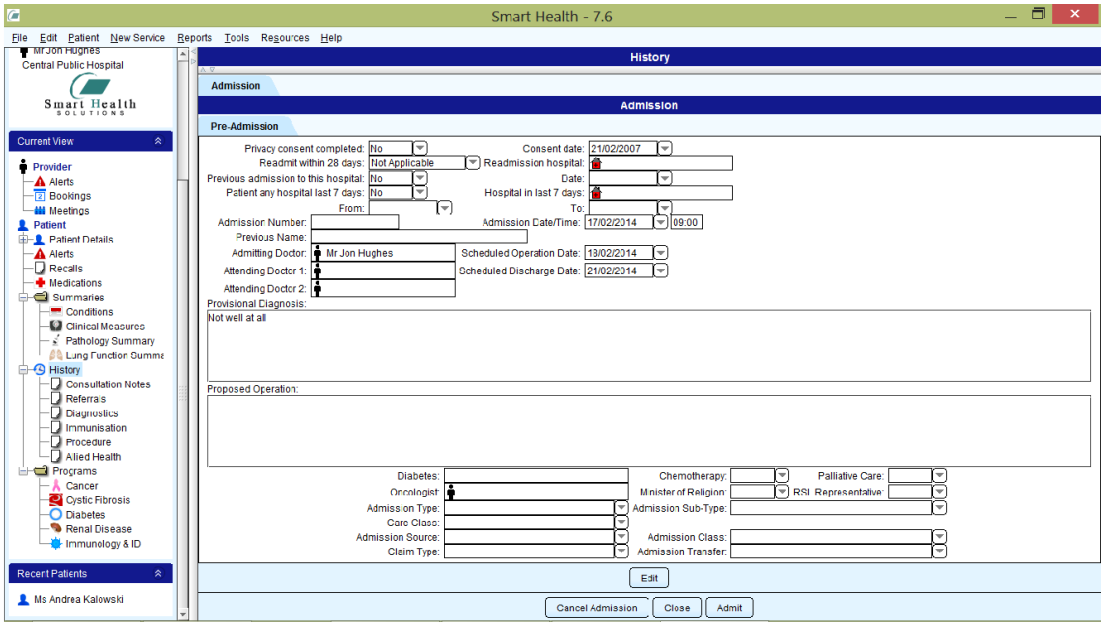
You will be prompted to enter a reason for the cancellation.



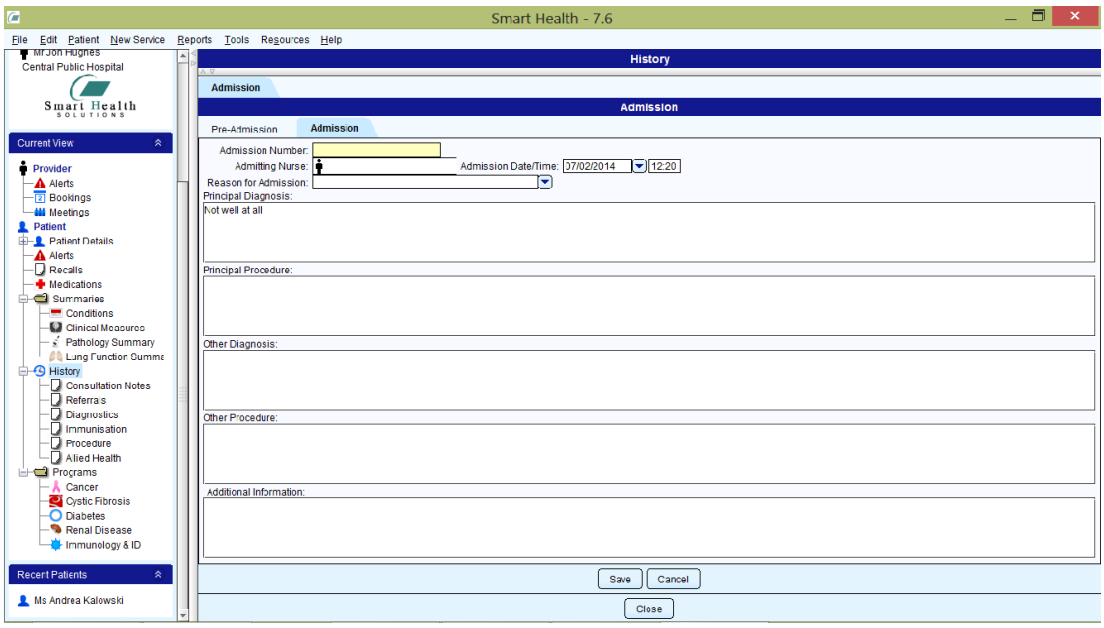
Type the reason for the cancellation and click OK.

10.2.3 Admission

Record patient admission by opening the Pre-Admission record and clicking Admit:

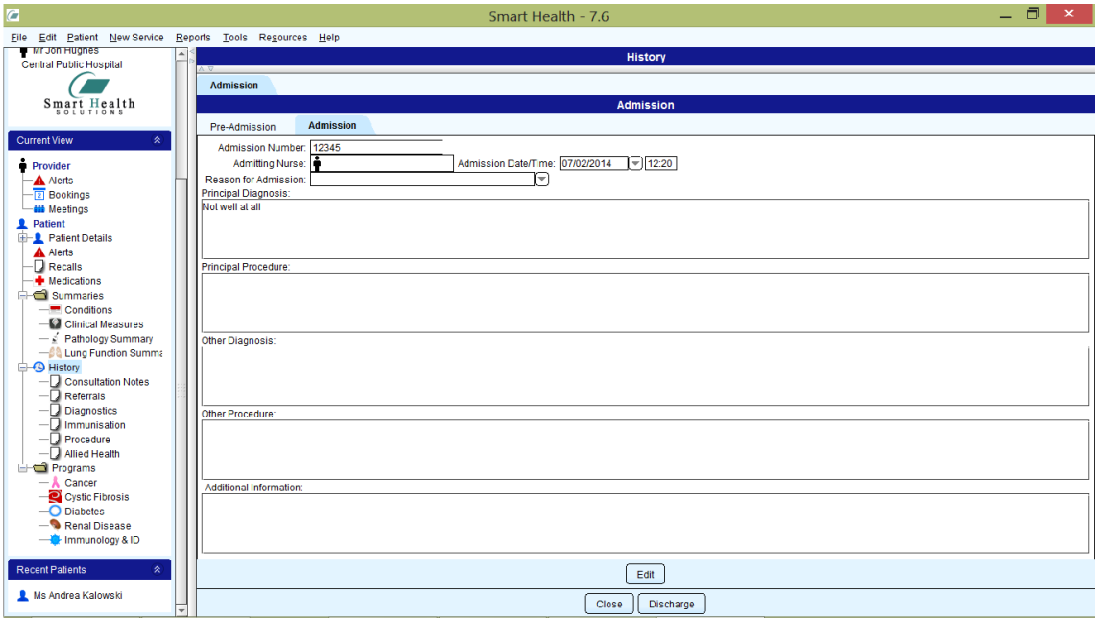


Complete all mandatory fields and click Save to save the record:



10.2.4 Discharge

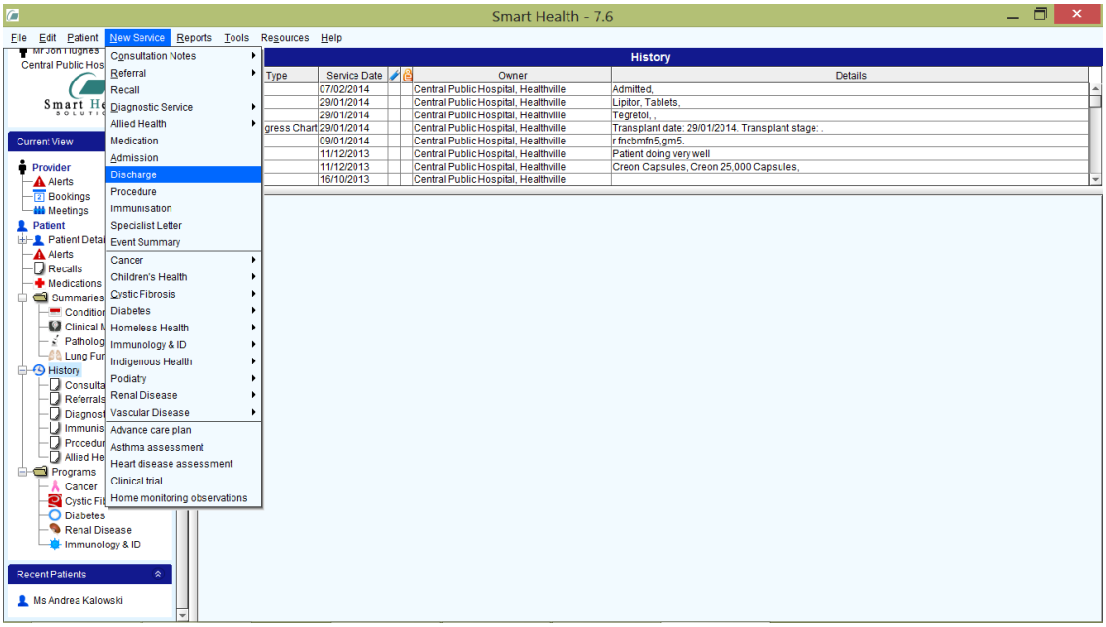
To record Discharge details, open the Admission record and click Discharge:



Discharge details are described in the next section.

10.3 Discharge

A Discharge summary can also be created without an Admission by selecting Discharge Summary from the New Service menu:

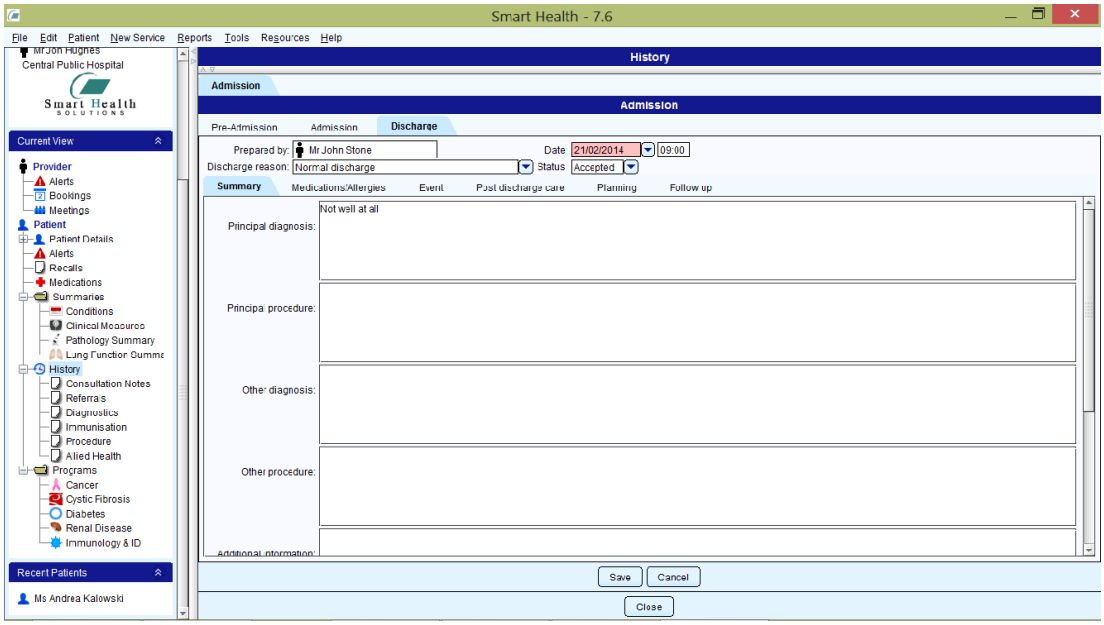


The Discharge Summary contains five tabs of information that may need to be completed:

When all fields have been entered, including all mandatory fields, click Save to save the Discharge Summary.

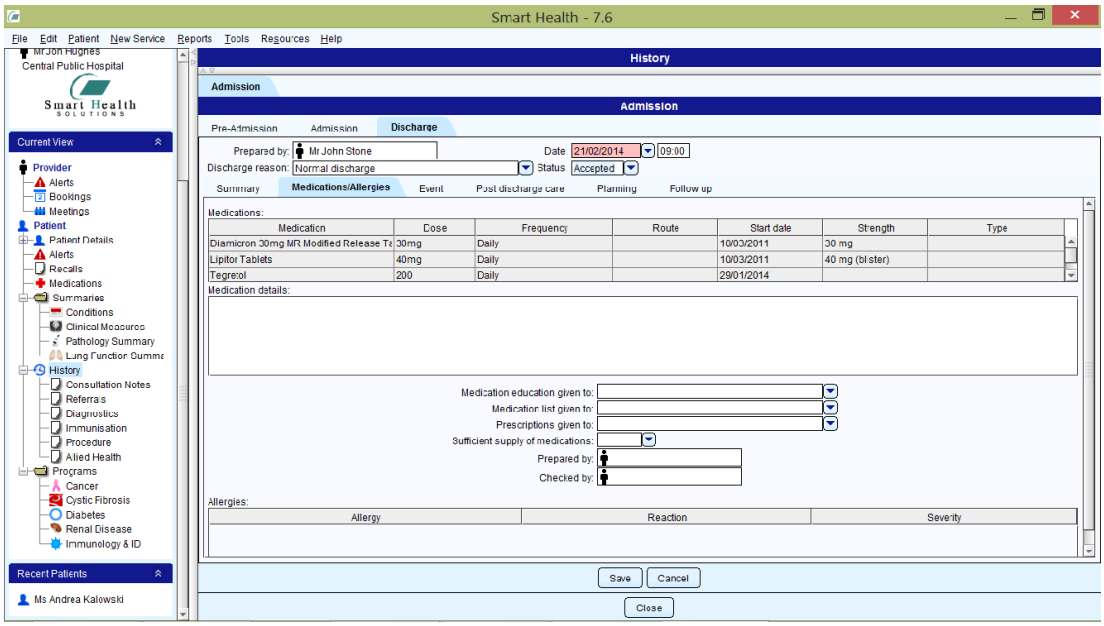
10.3.1 Summary

Fields in the Summary is populated from the Admission record if one exists.



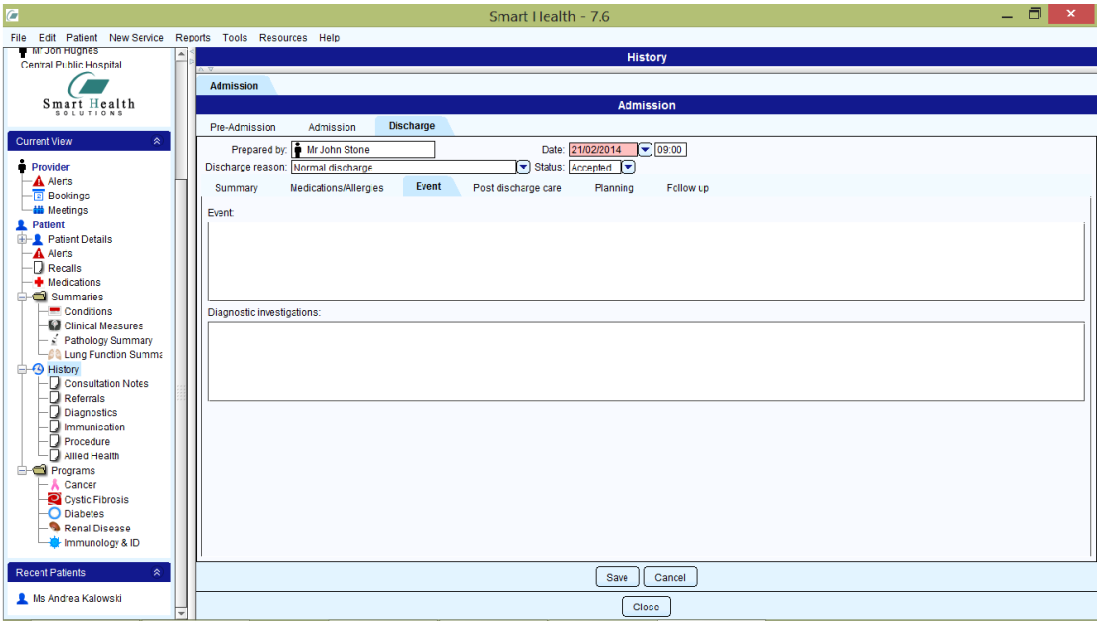
10.3.2 Medication List

The medication list is populated from the patient's current medications, if any.

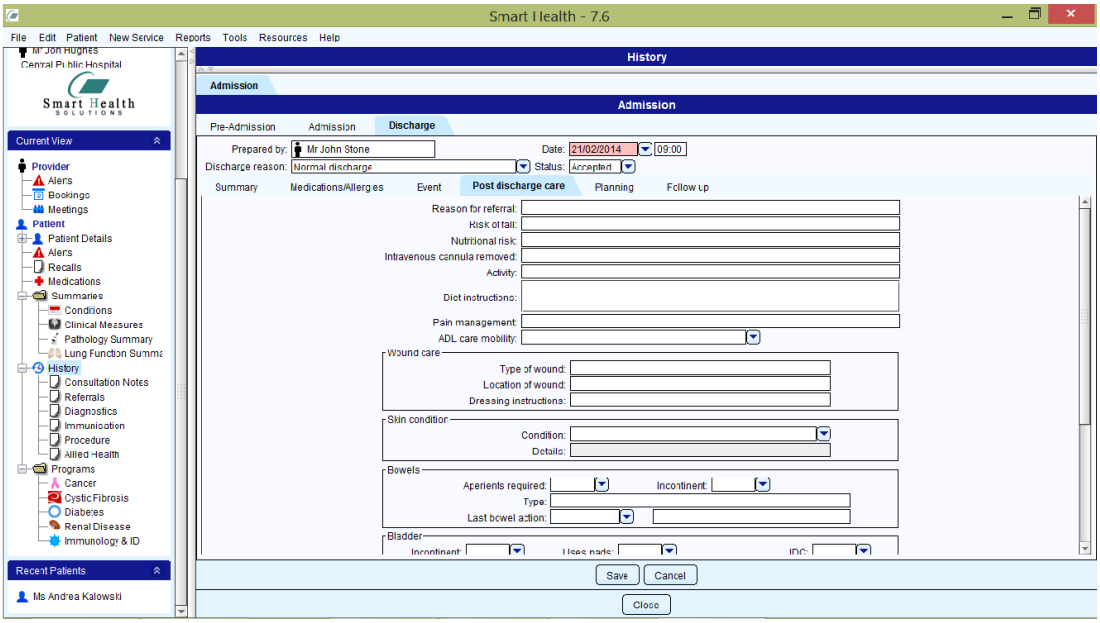


10.3.3 Event

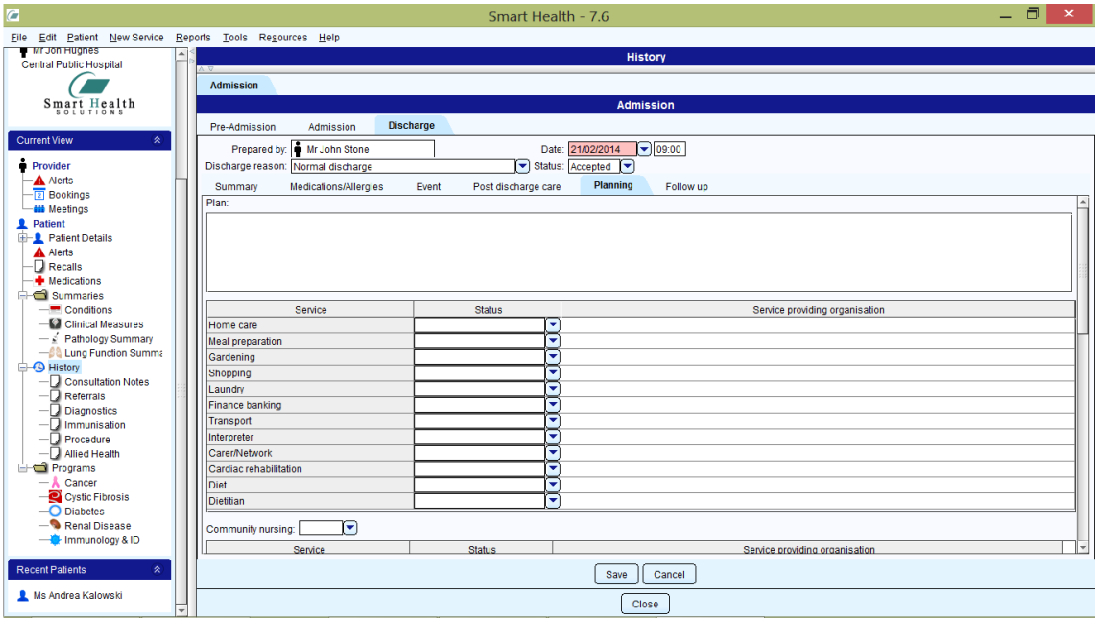
Records the details of the procedure for which the patient was admitted.



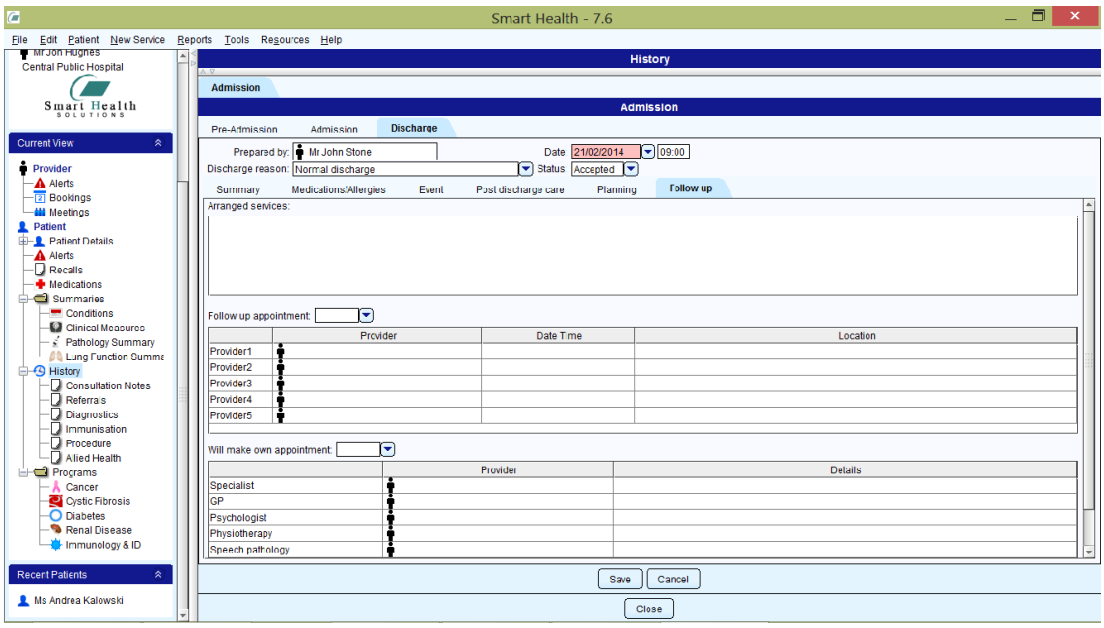
10.3.4 Post Discharge Care



10.3.5 Planning

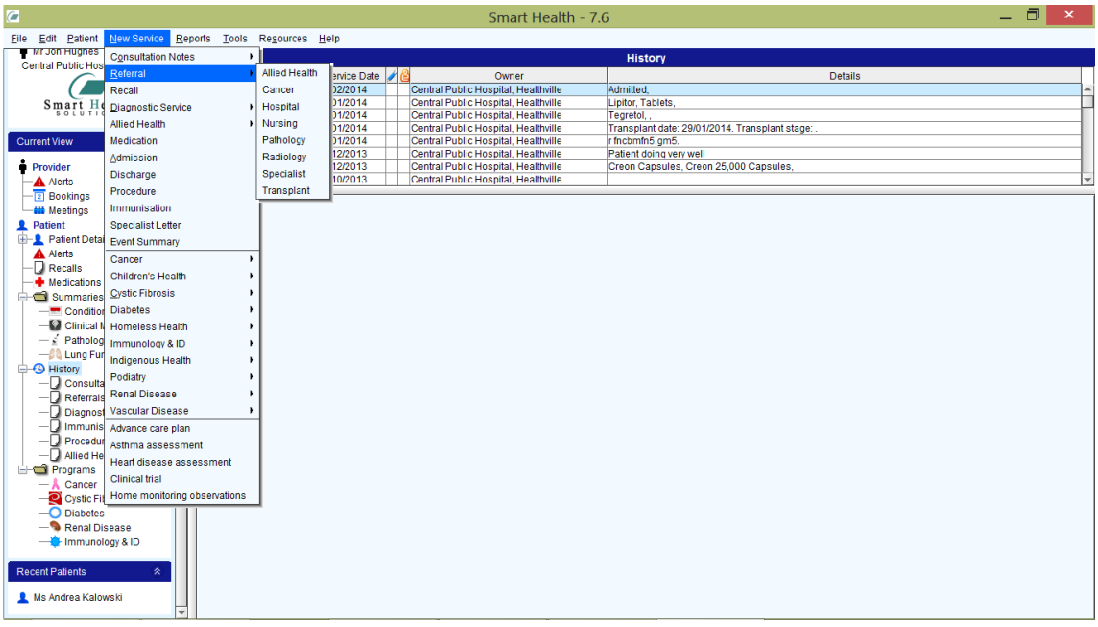


10.3.6 Follow Up



10.4 Referral

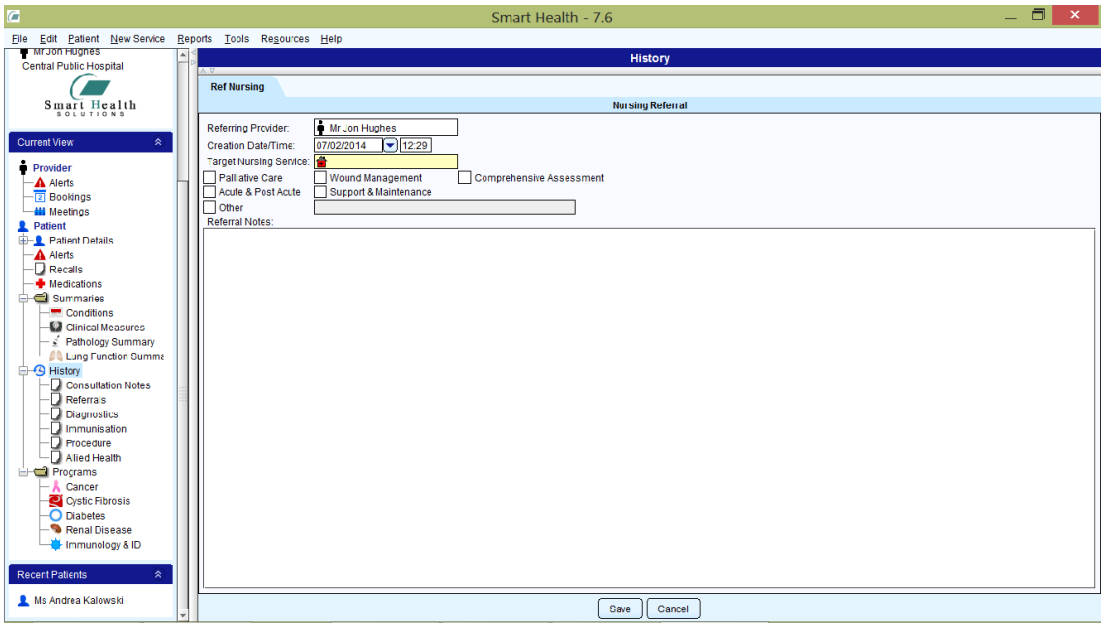
Create an electronic (or paper) referral to another participating healthcare provider by selecting a referral of the appropriate type from the New Service menu:



Smart Health supports Referrals to:

- Allied Health
- Cancer

- Hospital (admission request)
- Nursing
- Pathology (diagnostic request)
- Radiology (diagnostic request)
- Specialist
- Transplant



Complete all fields (particularly mandatory fields) and click Save to save the referral. The provider to whom the patient has been referred will be alerted that the referral has been created.

If the target Provider is not a Smart Health user, the Referral can be printed, signed and handed to the patient to take to the new Provider.

10.5 Pathology

Use a Pathology referral to create a request for Pathology diagnostic tests. The Referral can be printed, signed and handed to the patient to take to the Pathology provider.

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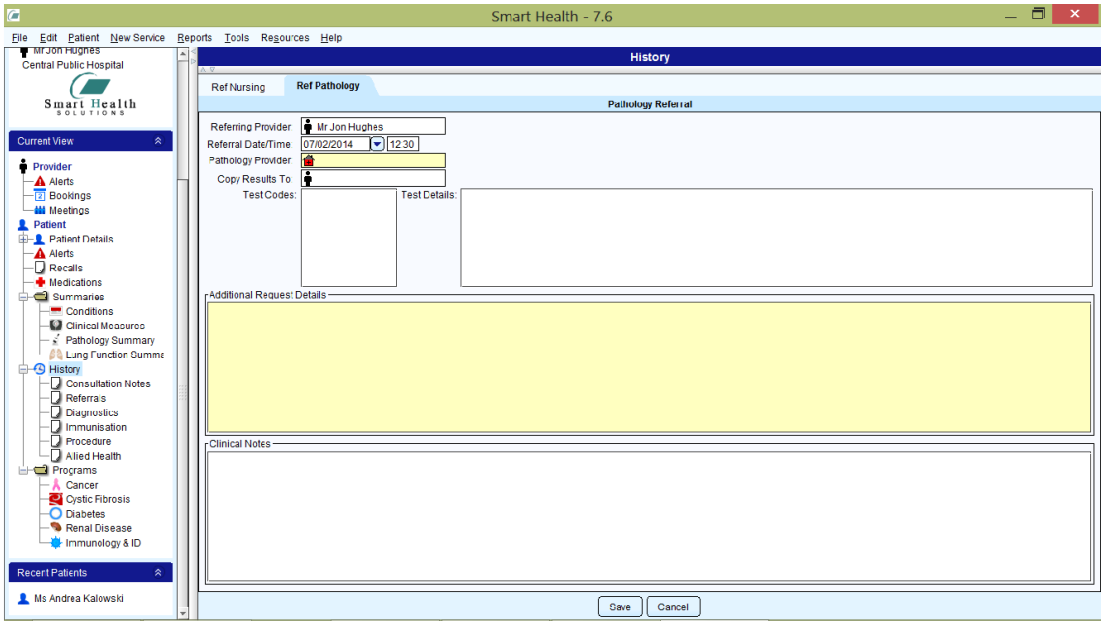
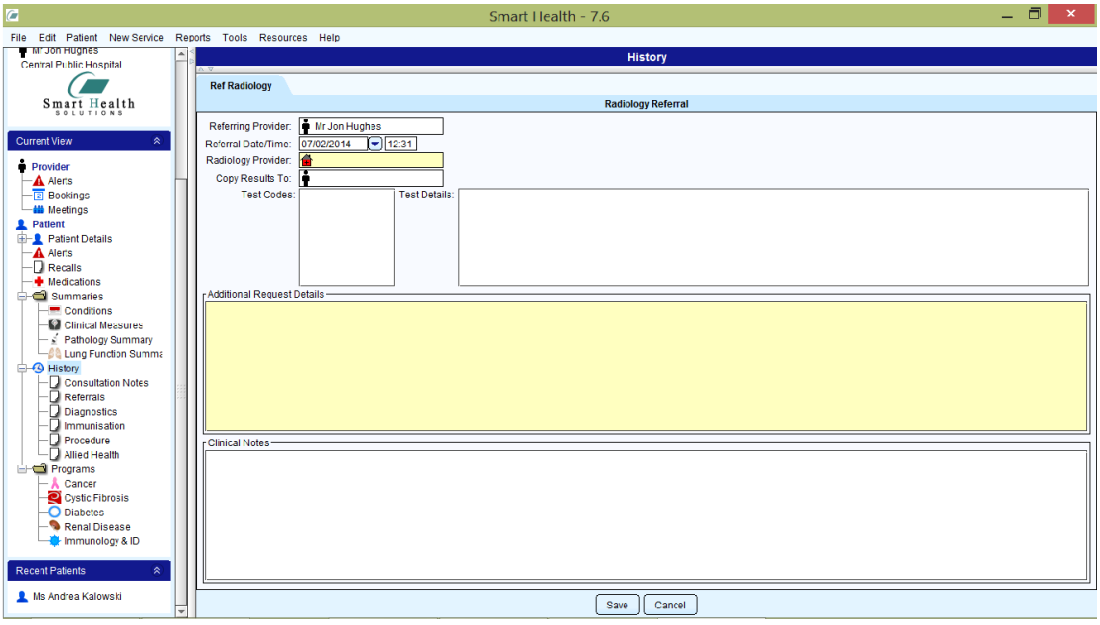


10.6 Radiology

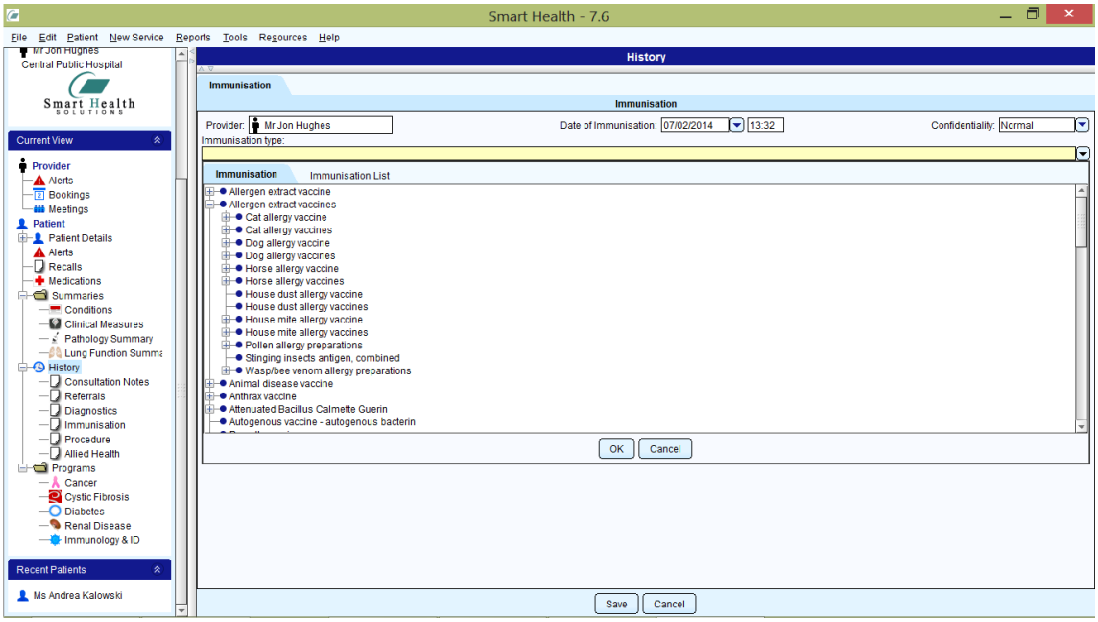
Use a Radiology referral to create a request for Diagnostic Imaging diagnostic tests. The Referral can be printed, signed and handed to the patient to take to the Radiology provider.



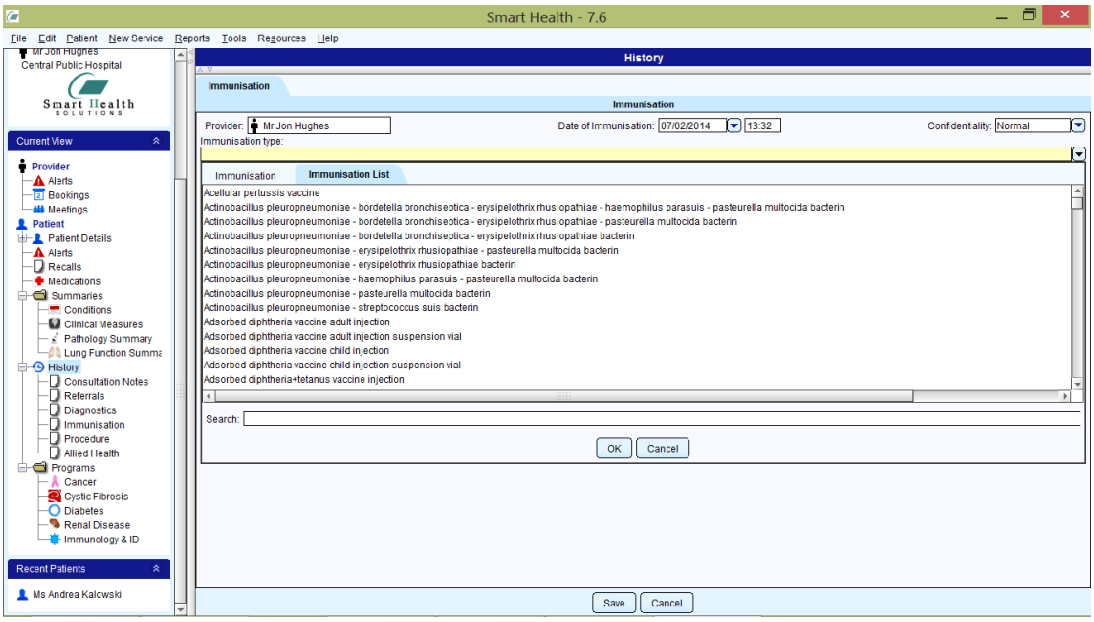
10.7 Immunisation

Create a new Immunisation by selecting Immunisation from the New Service menu. Select an Immunisation from the SNOMED CT list of Immunisation types by clicking the Immunisation type selection box.

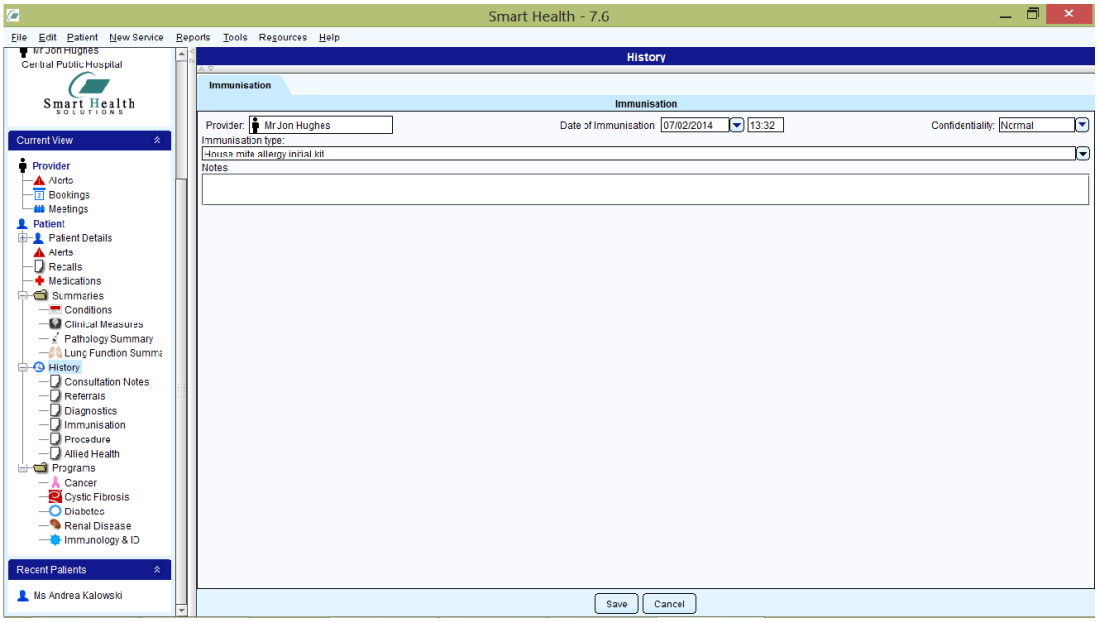
More detailed entries may be viewed by clicking the "+" symbols in the SNOMED CT tree:



The second Tab (Immunisation List) includes a Search function to search alphabetically for a specific Immunisation.



Select an Immunisation and click OK.

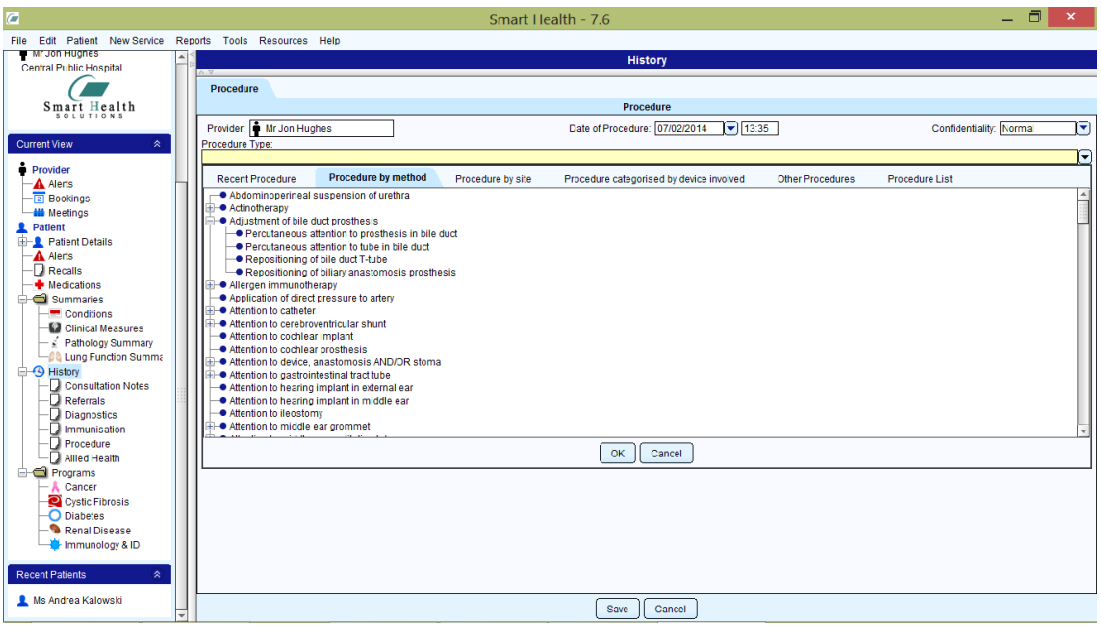


Add any additional notes in the next pane and click Save to save the record.

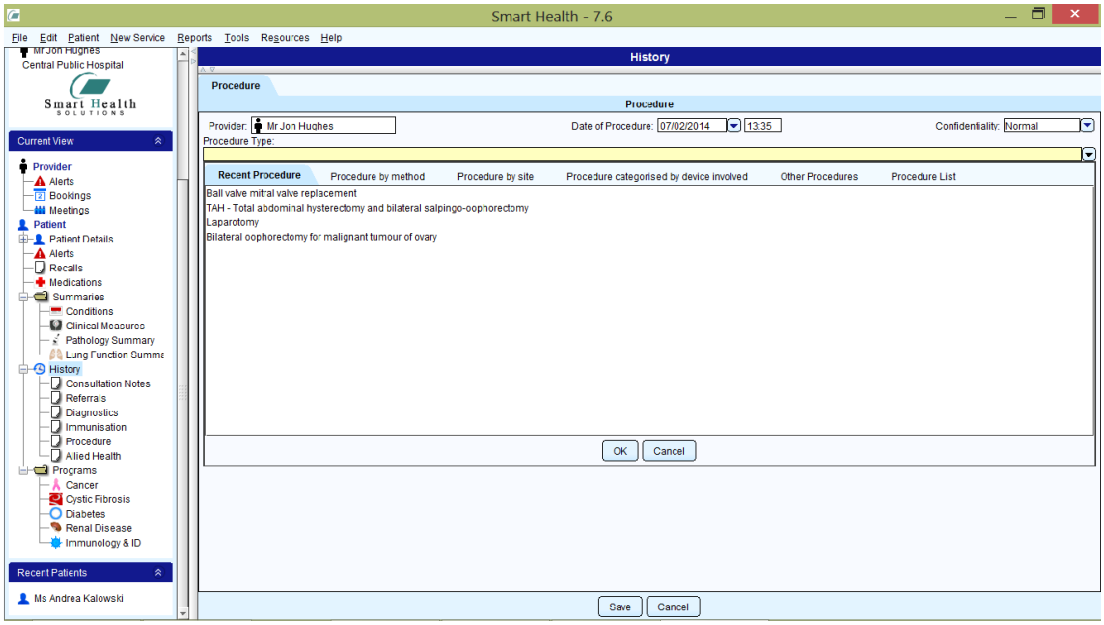
10.8 Procedure

Create a new Procedure by selecting Procedure from the New Service menu. Select a Procedure from the SNOMED CT list of Procedure types by clicking the Procedure type selection box.

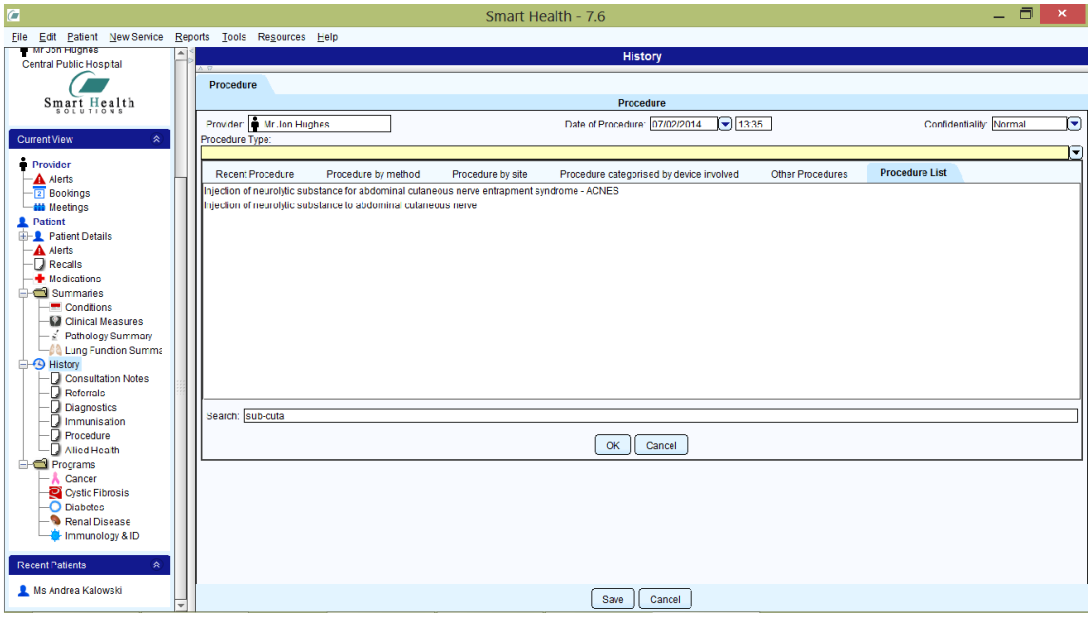
More detailed entries may be viewed by clicking the “+” symbols in the SNOMED CT tree.



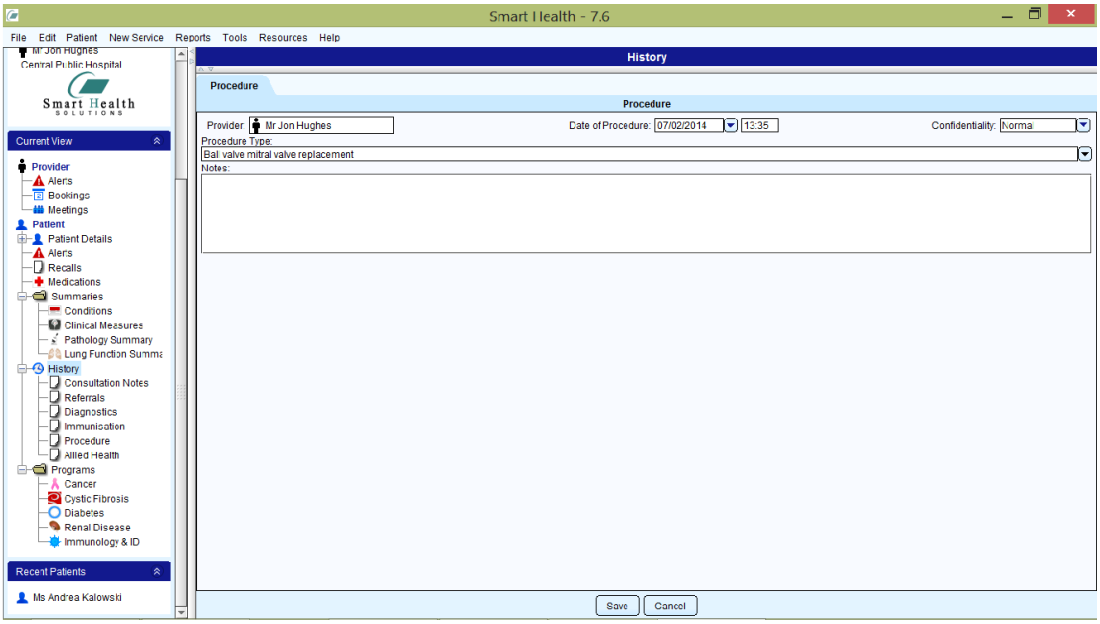
The first Tab (Recent Procedures) lists only the Procedures that have been previously selected by users in your Practice.



The fifth Tab (Procedure List) includes a Search function to search alphabetically for a specific Procedure.



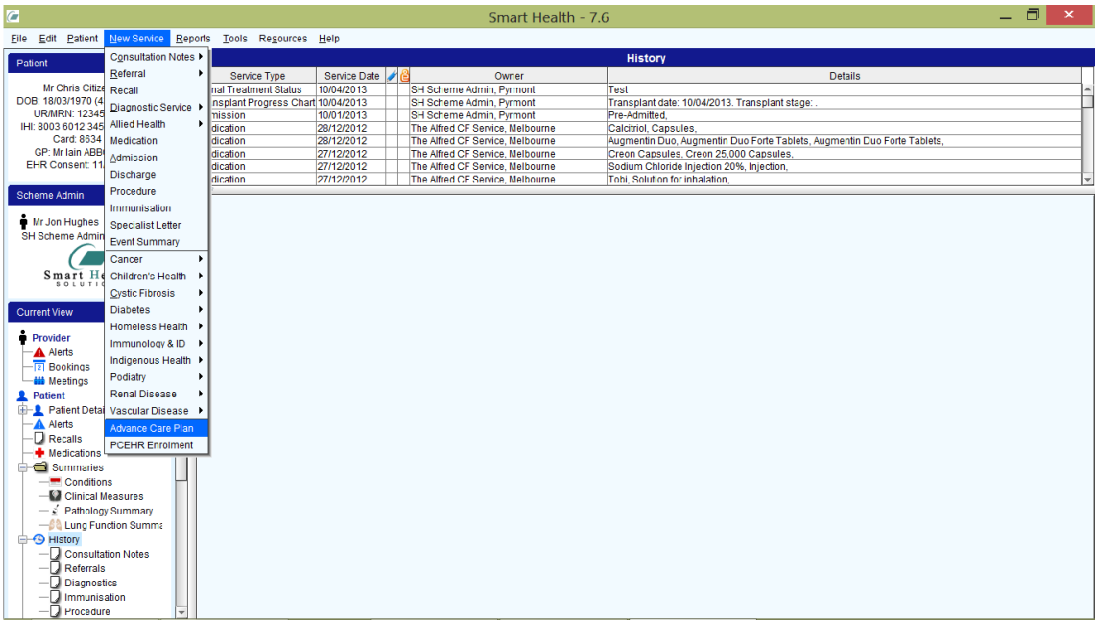
Select a Procedure and click OK.



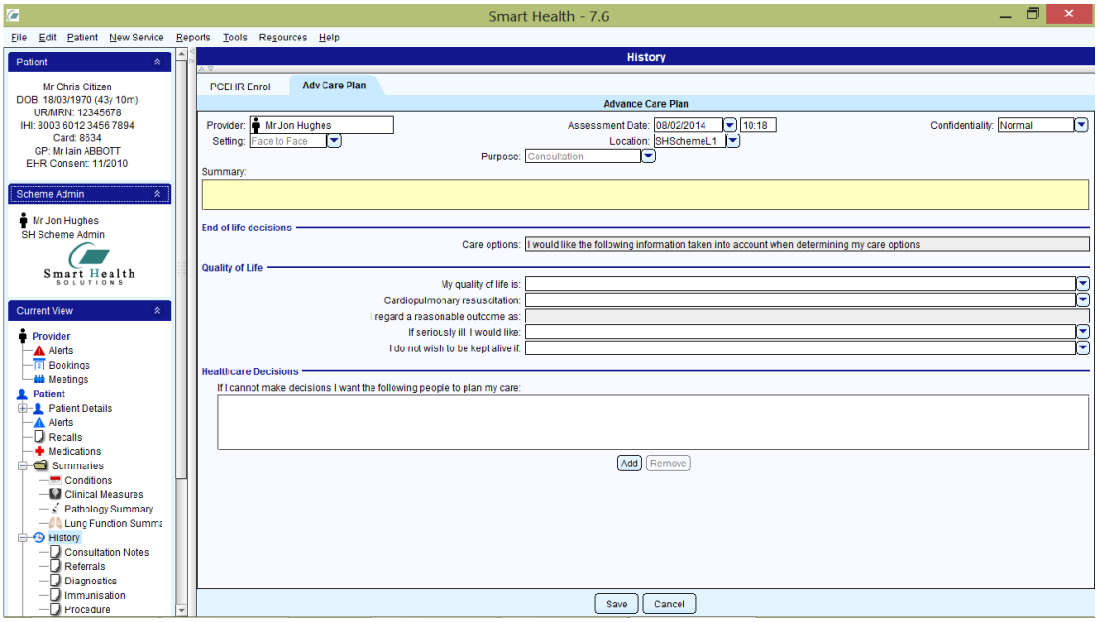
Add any additional notes and click Save to save the record.

10.9 Advance Care Plan

Smart Health provides a short-form Advance Care Plan for patients. It can be created from the New Service menu:



10.9.1 Advance Care Plan:



11. CHRONIC DISEASE & MANAGED HEALTH PROGRAM RECORDS

Smart Health chronic disease and health management programs have detailed sets of clinical forms specially designed to support the data capture, management and reporting requirements of those programs.

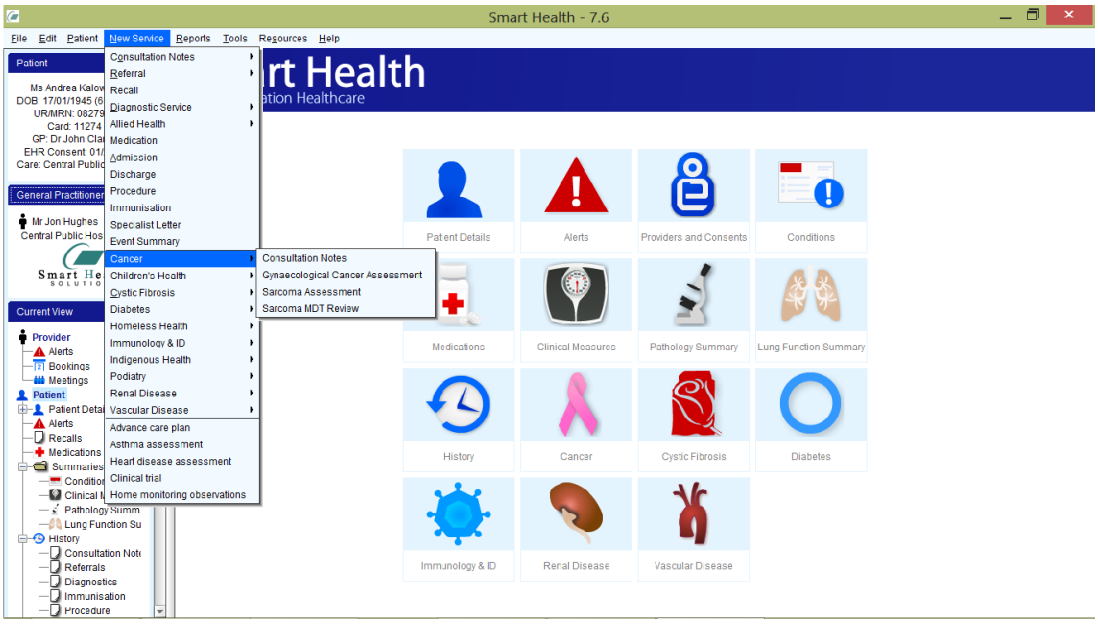
Health service records (event records) for these programs are grouped in the Navigation tree, making it easy to review patients' managed health programs.

New forms for these programs are selected from the New Service menu, using the menu items that are listed for the health management programs (Cancer, Cystic Fibrosis, Diabetes, Kidney Disease, Immunology & Infectious Diseases and Vascular Disease).

11.1 Cancer

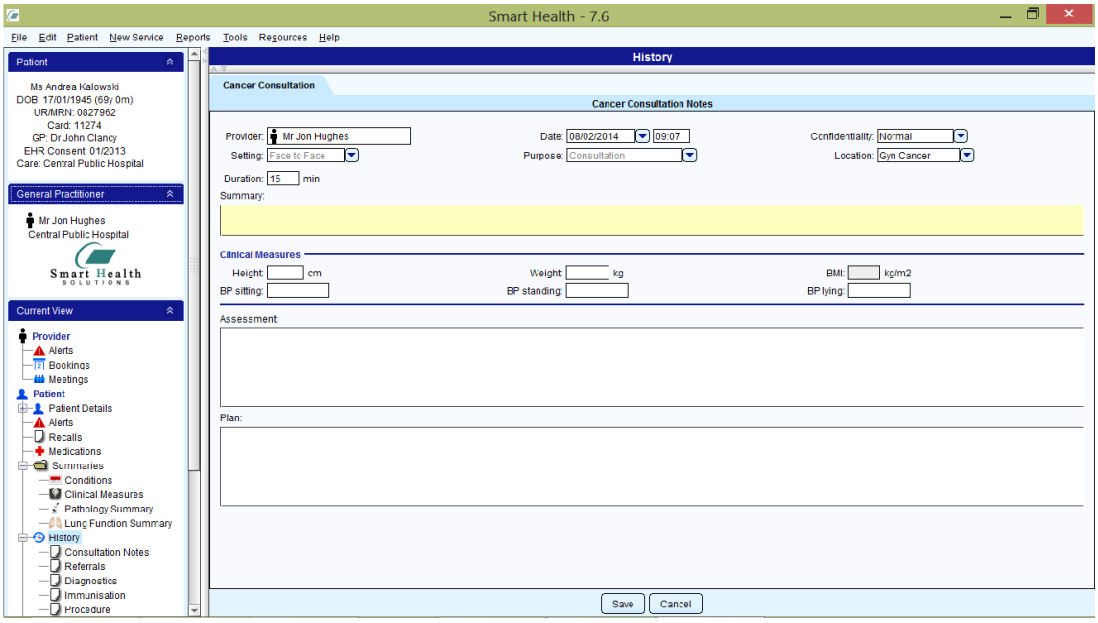
Smart Health support outpatient and ambulatory care for cancer patients, and in particular, multidisciplinary team management of patients who have undergone intervention treatment for cancer.

Create new cancer service records from the New Service/Cancer menu:



11.1.1 Cancer Consultation Notes

Cancer consultation notes are the same for all Cancers (tumour stream) and are grouped with other cancer clinical records in the Cancer Program filtered view of the patient's record history.

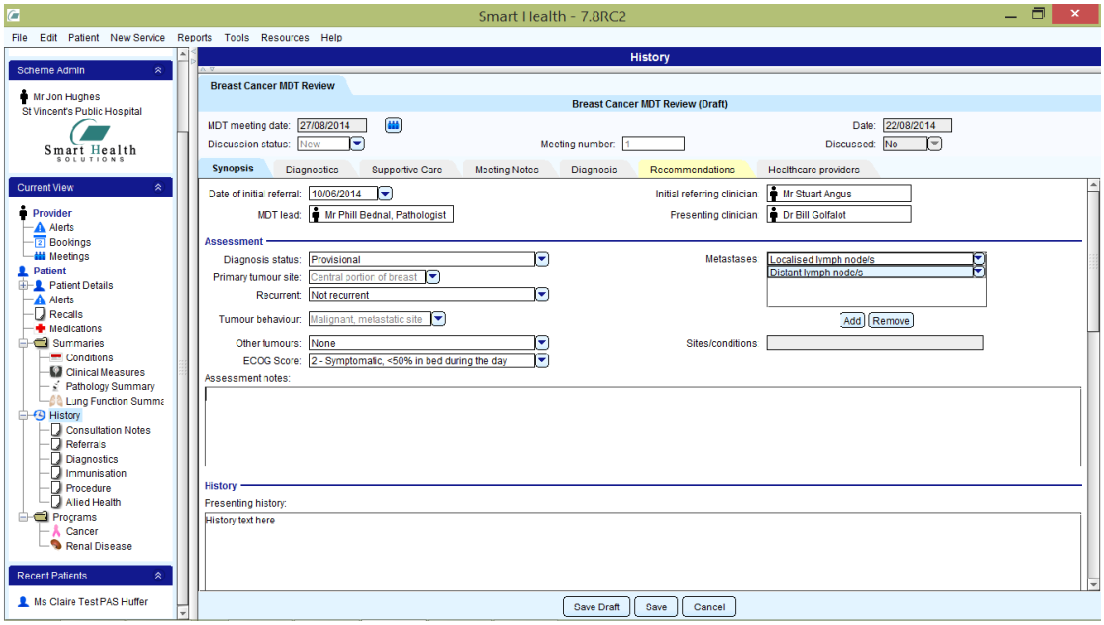


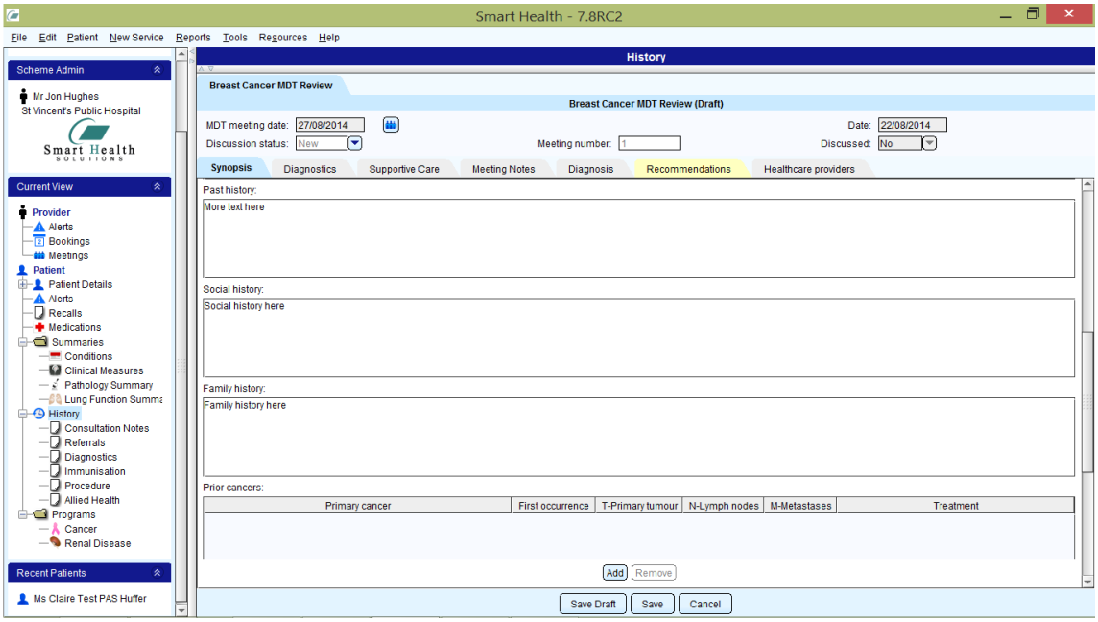
11.1.2 Multi-disciplinary Team Review

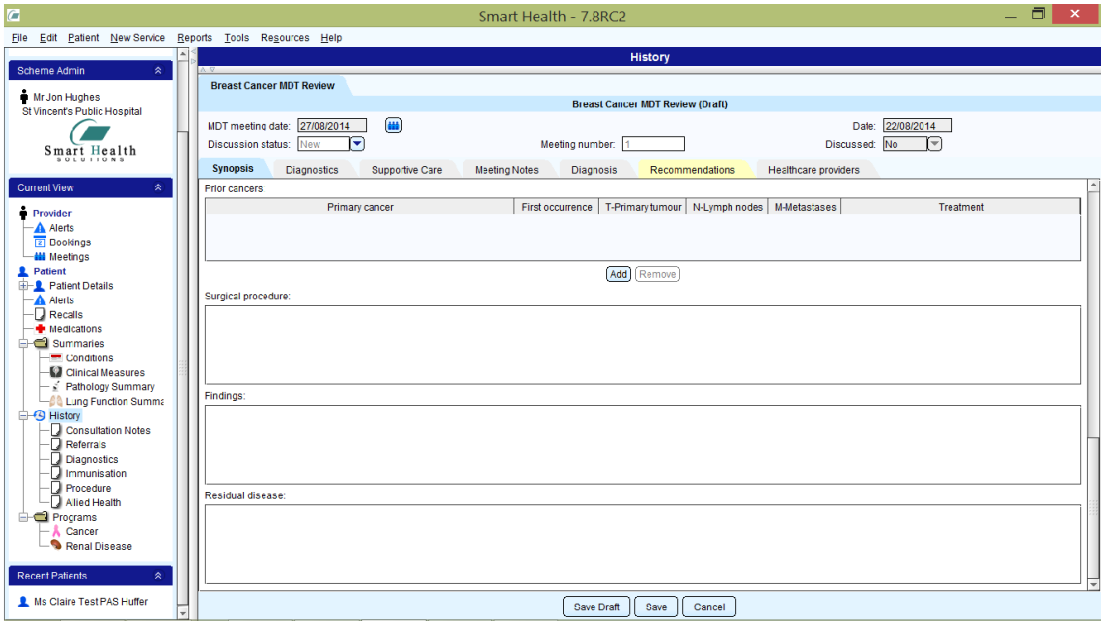
MDT Reviews are created by Smart Health when a patient is added to the agenda of a Multidisciplinary Team Meeting.

Most of the information in these Reviews is common across Cancers (Tumour Streams). The Diagnosis Tab (see below) and some selected data fields may be tumour stream specific.

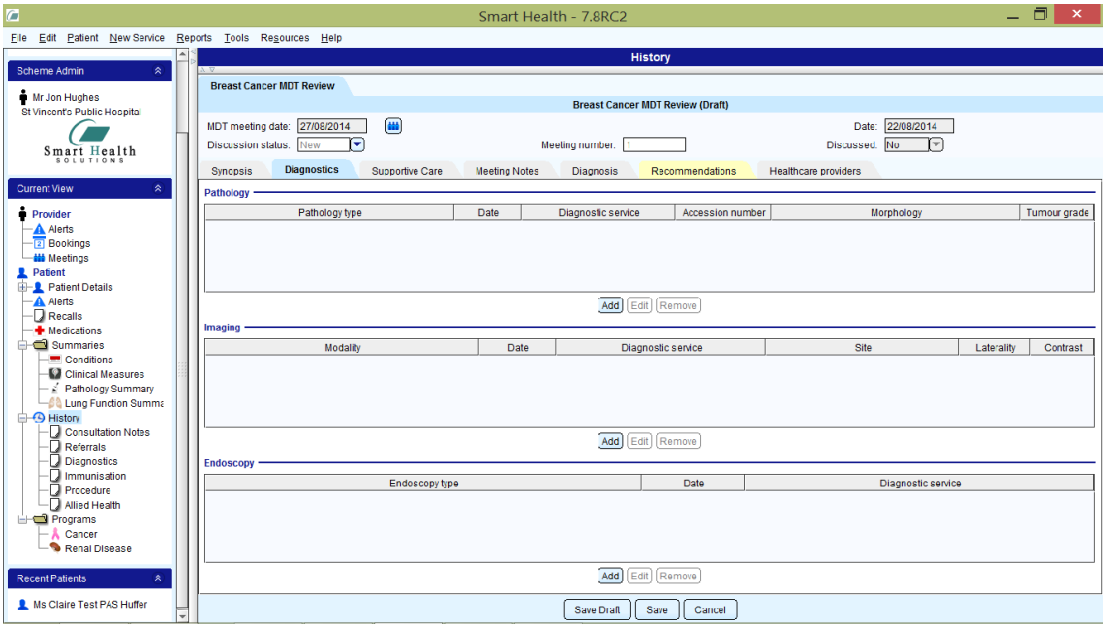
Synopsis:







Diagnostics:



Selecting the Add button for a diagnostic type opens a dialog to enter diagnostic data. For example, clicking Add (Pathology) causes the following screen to be displayed:

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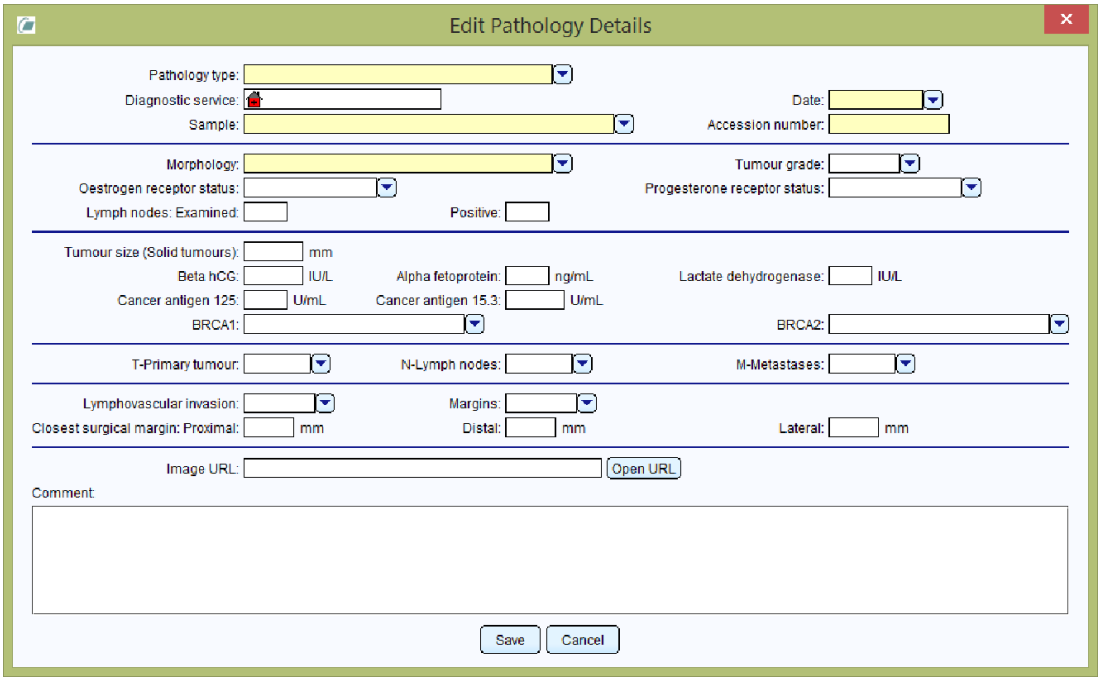
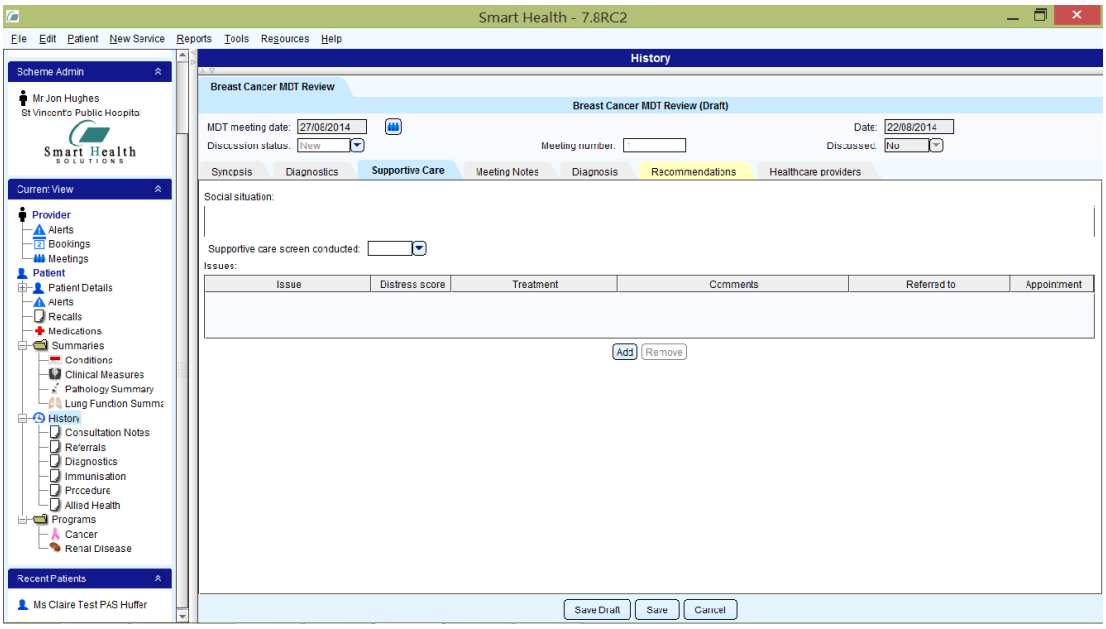
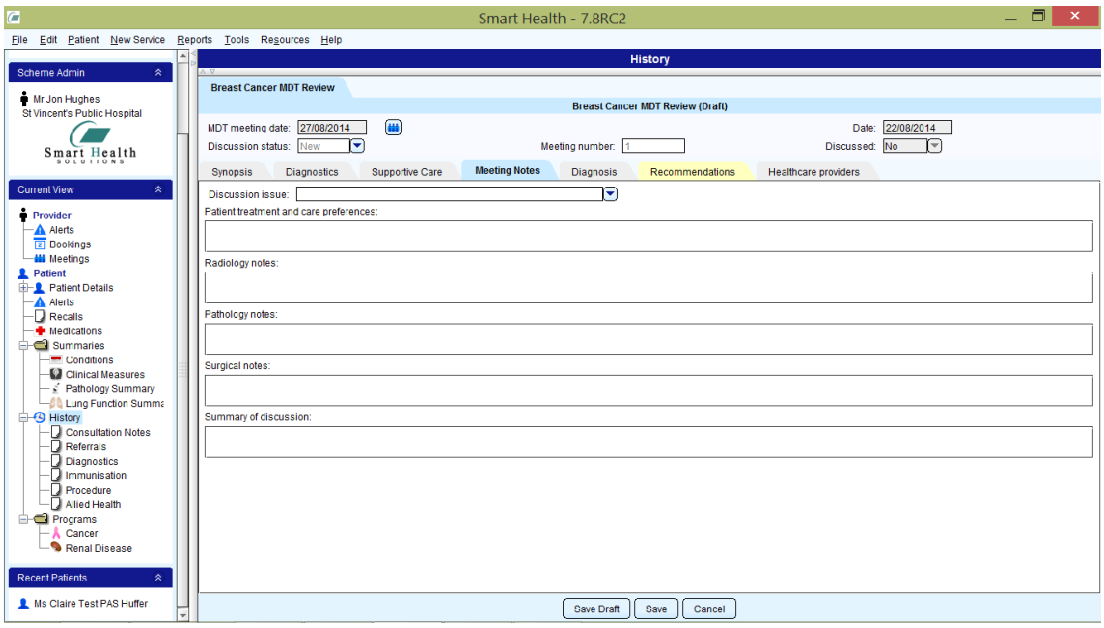


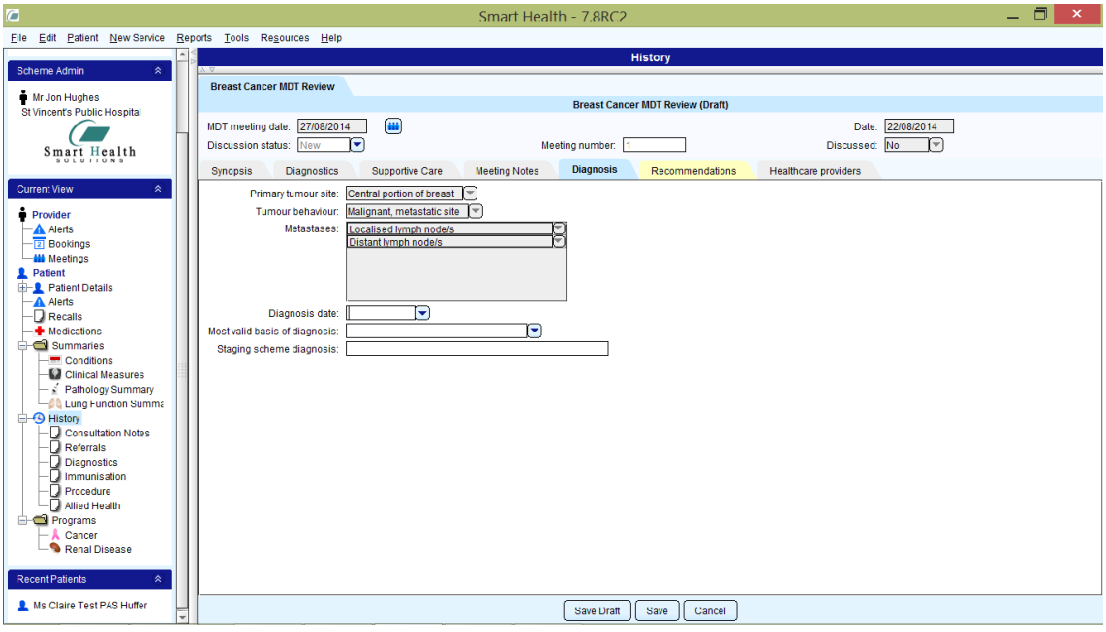
Supportive care:



Meeting Notes:



Diagnosis:



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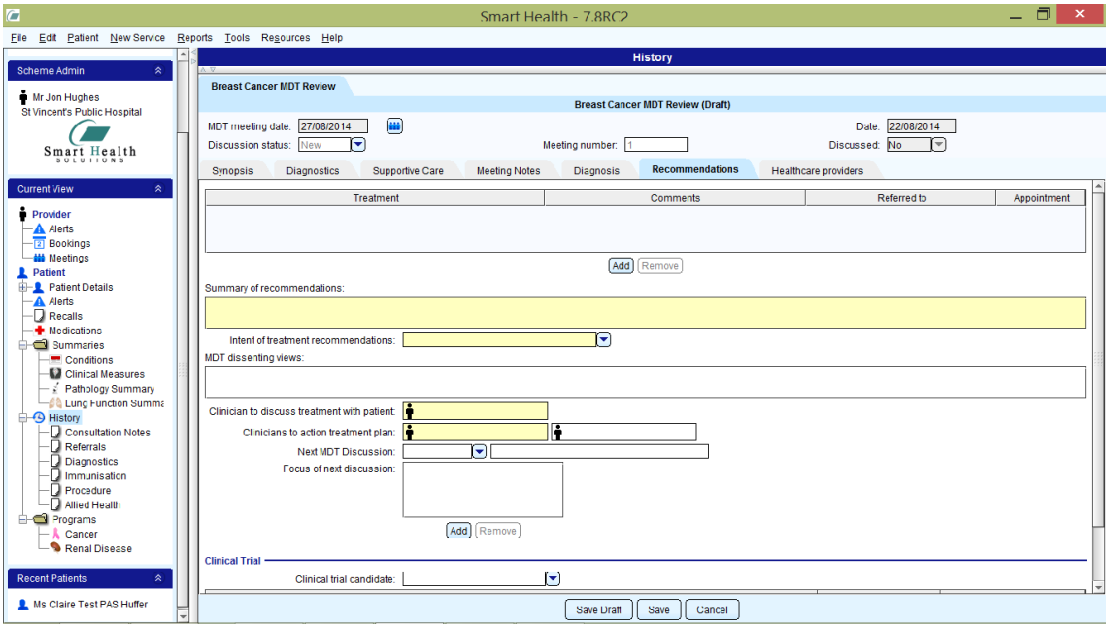
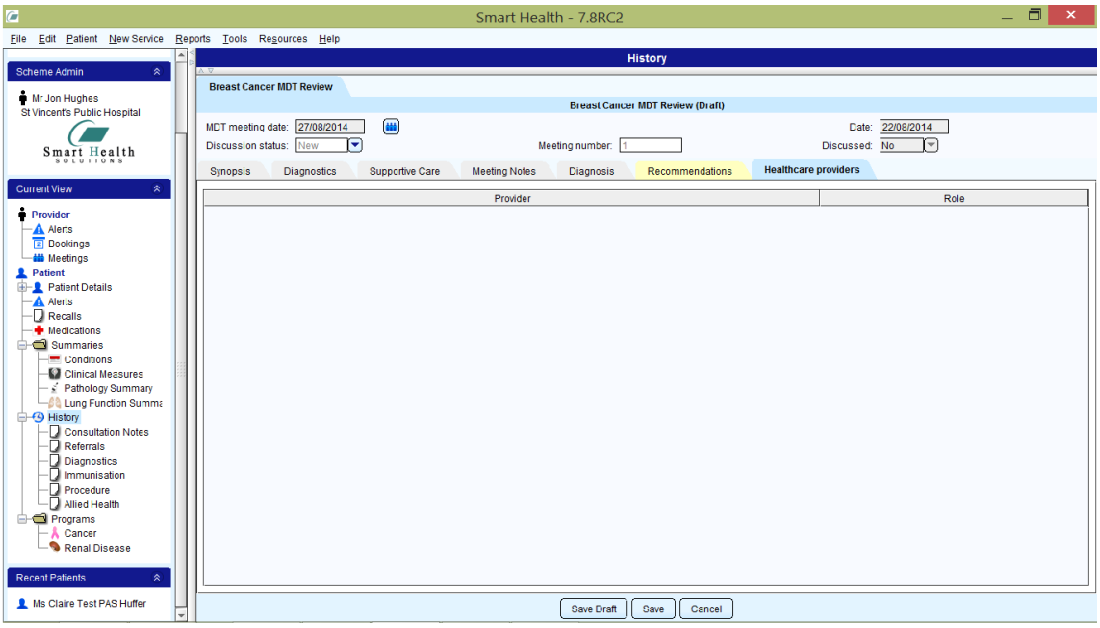
Recommendations:



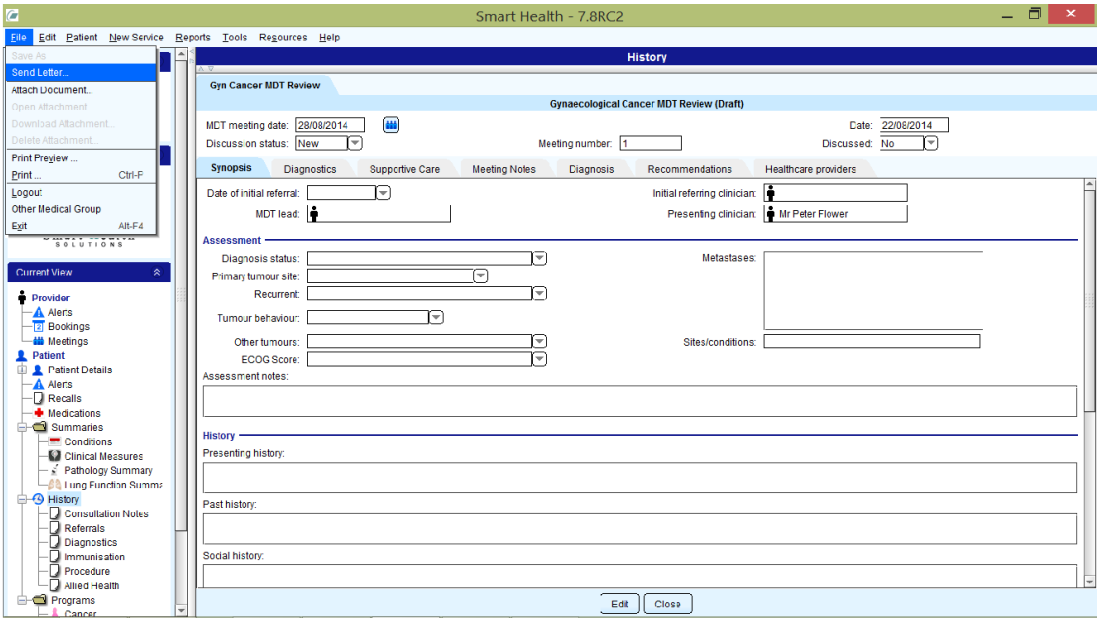
Providers:



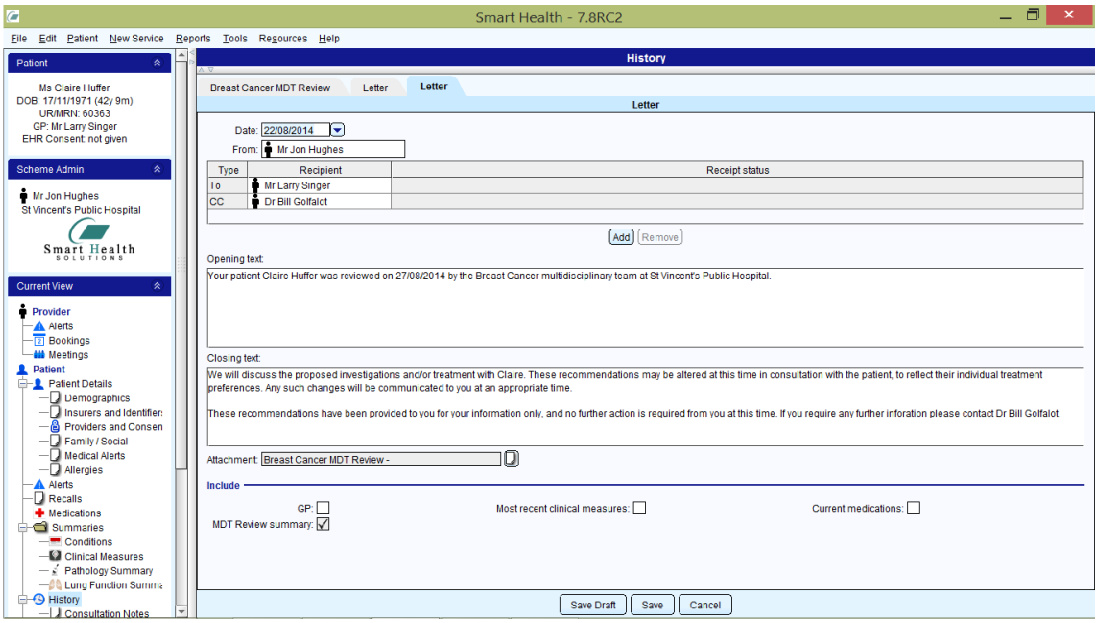
11.1.2.1 MDT Review Letter

When an MDT Review is open, it can be used to create a Letter, populate MDT Review data to the Letter and then be attached to the Letter. The letter can be printed, together with its attached MDT Review.

From the Main Menu, select File/Send Letter:



A Letter form is opened, with pre-populated text in most fields. If the patient has a recorded GP, the GP is the default recipient of the Letter (To:); other providers from the MDT Review are also populated to the Letter as CC: recipients. There are options to include recent clinical measures and current medications in the Letter.



Edit/update the fields in the Letter form and click Save Draft or Save (Final). When the Letter has been Saved (Final), it can no longer be edited. Click the Open PDF button to open a PDF presentation of the Letter and attached MDT Review.

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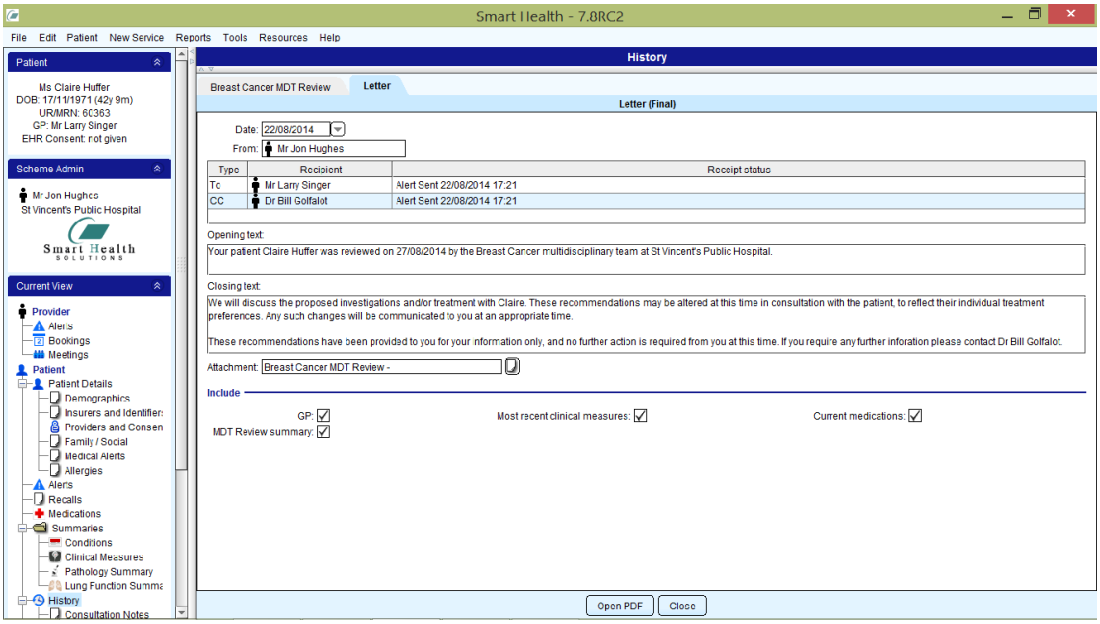
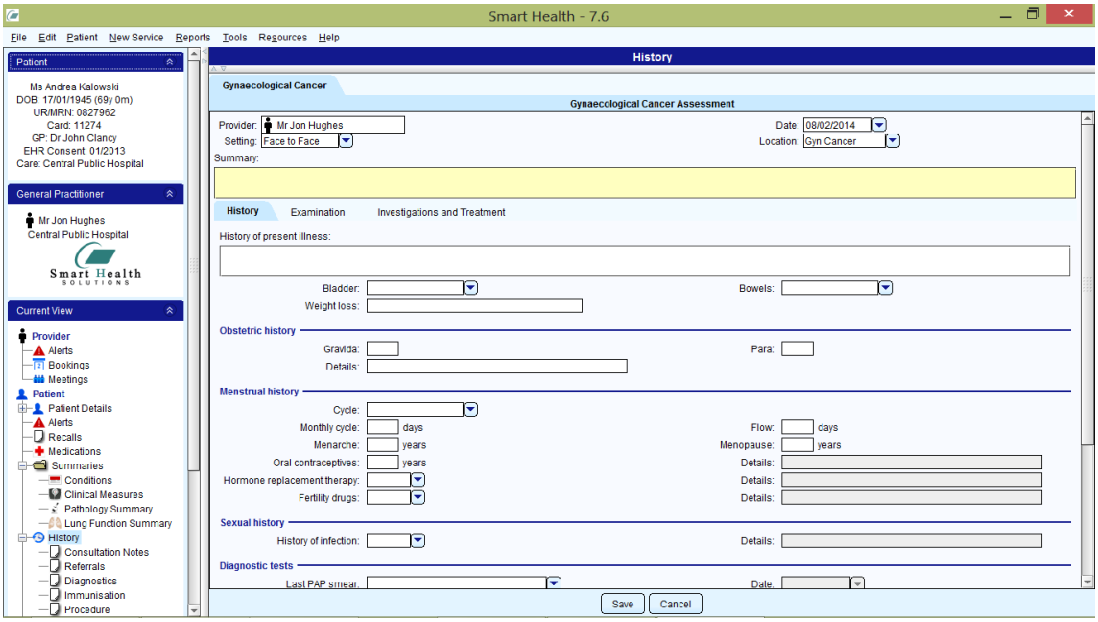
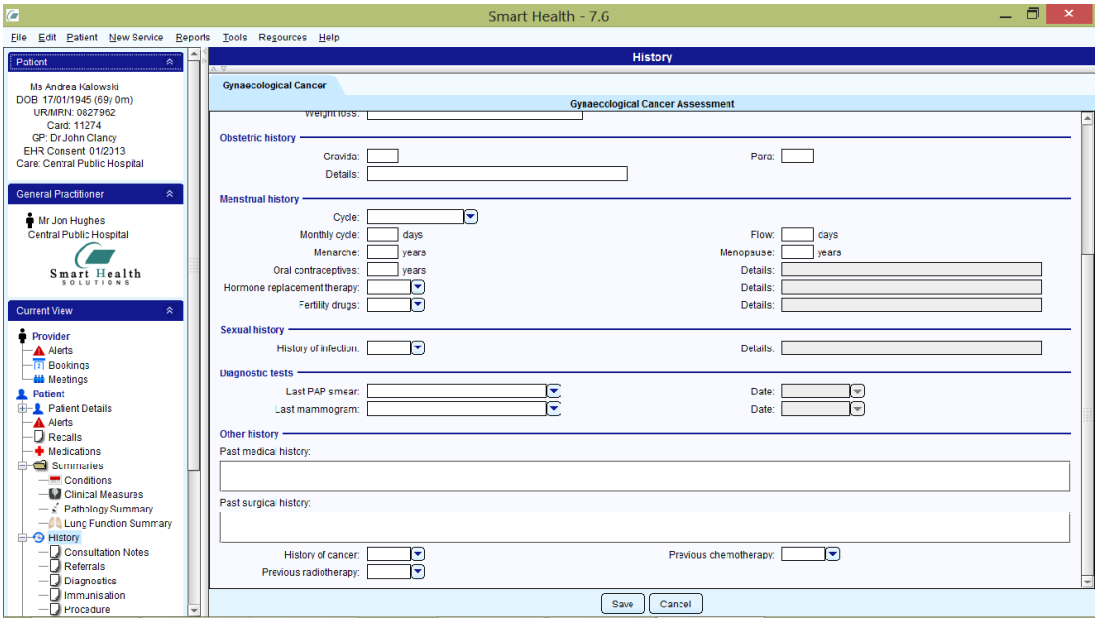
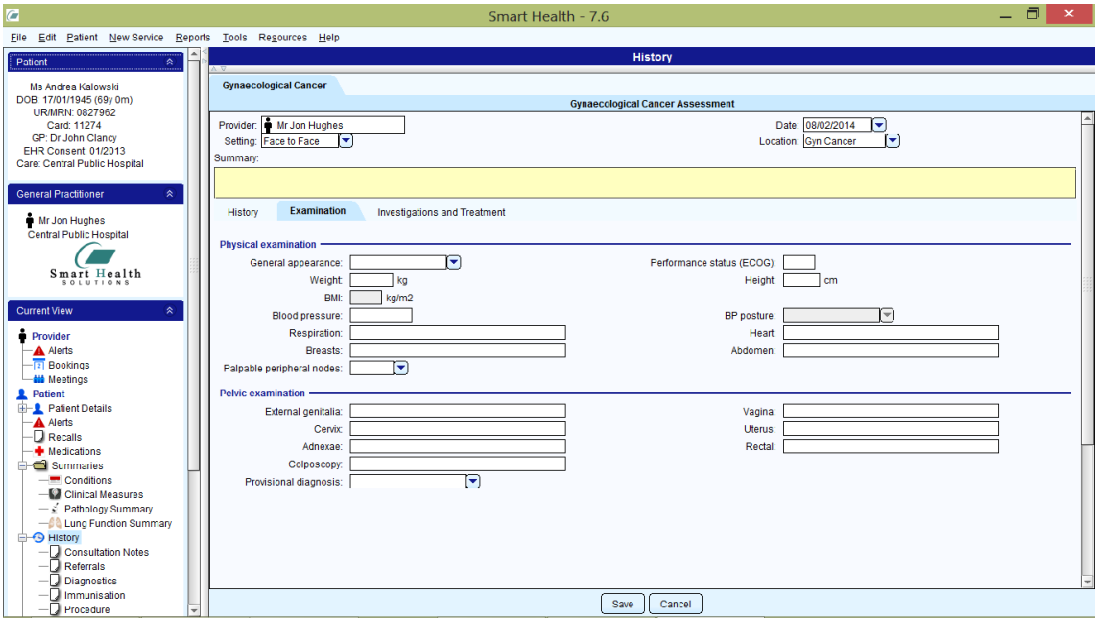


11.1.3 Gynaecological Cancer

11.1.3.1 Gynaecological Cancer Assessment




Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Gynaecological Cancer
Gynaecological Cancer Assessment
Obstetric history
Gravida:
Para:
Details:
Menstrual history
Cycle:
Monthly cycle: days
Flow: days
Menarche: years
Menopause: years
Oral contraceptives: years
Details:
Hormone replacement therapy:
Details:
Fertility drugs:
Details:
Sexual history
History of infection:
Details:
Diagnostic tests
Last PAP smear:
Date:
Last mammogram:
Date:
Other history
Past medical history:
Past surgical history:
History of cancer:
Previous chemotherapy:
Previous radiotherapy:
Save
Cancel


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
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UR/MRN: 0827962
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General Practitioner
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Central Public Hospital
Current View
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Alerts
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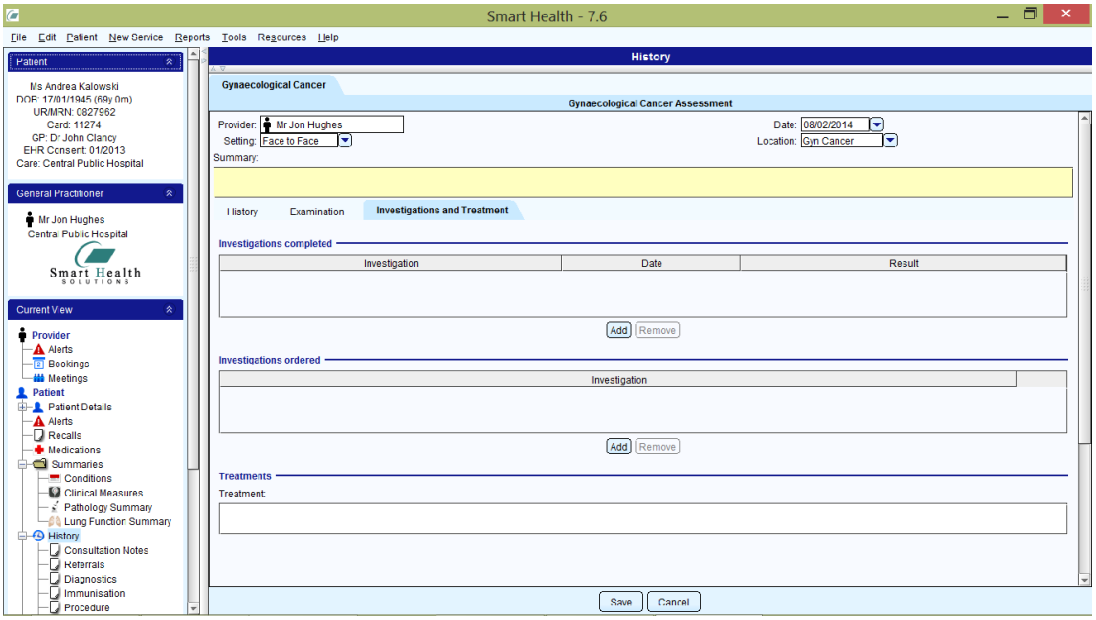
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Gynaecological Cancer
Gynaecological Cancer Assessment
Provider: Mr Jon Hughes
Date: 08/02/2014
Setting: Face to Face
Location: Gyn Cancer
Summary:
History
Examination
Investigations and Treatment
Physical examination
General appearance:
Performance status (ECOG):
Weight: kg
Height: cm
BMI: kg/m2
Blood pressure:
BP posture:
Respiration:
Heart:
Breasts:
Abdomen:
Palpable peripheral nodes:
Pelvic examination
External genitalia:
Vagina:
Cervix:
Uterus:
Adnexae:
Rectal:
Colposcopy:
Provisional diagnosis:
Save
Cancel



11.1.4 Breast Cancer

There are no Breast Cancer specific clinical records.

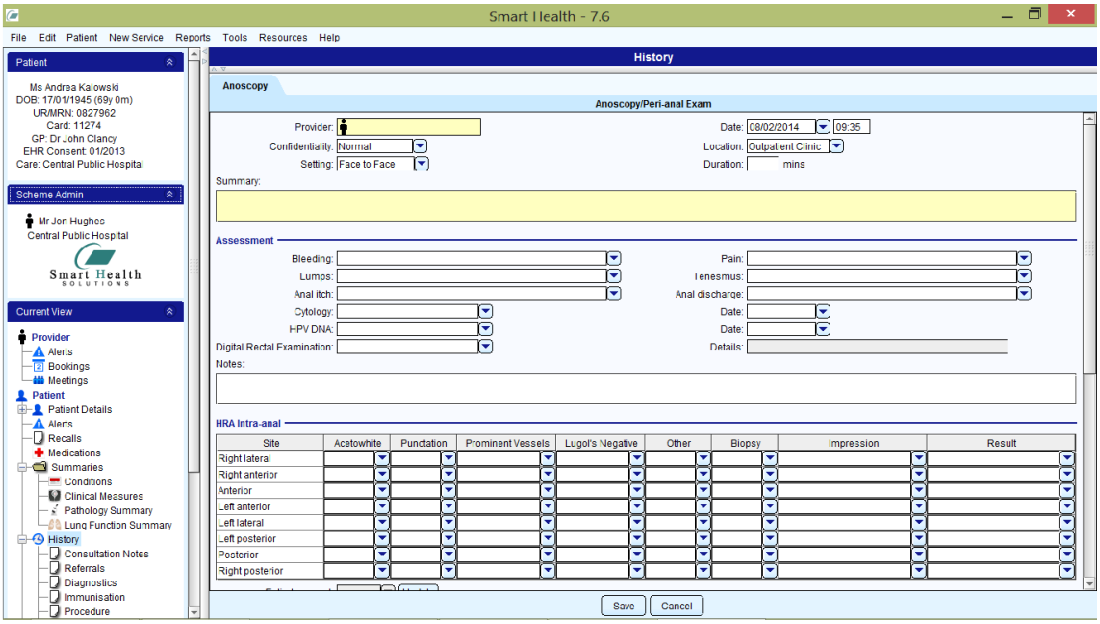
11.1.5 Lung Cancer

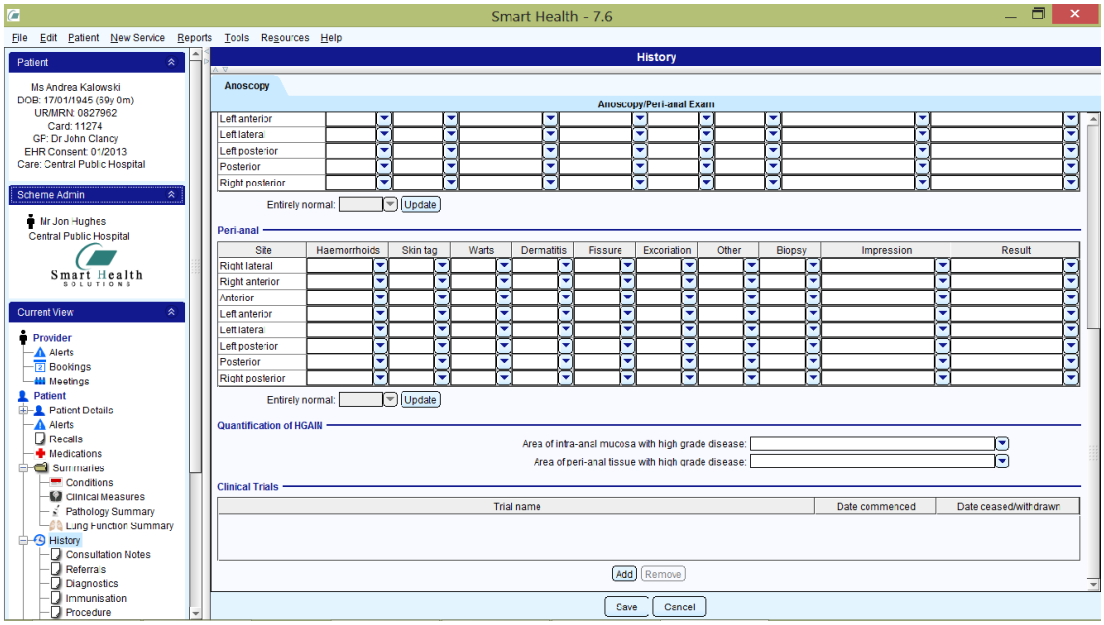
There are no Lung Cancer specific clinical records.

11.1.6 Colorectal Cancer

11.1.6.1 Anoscopy/Peri-anal Exam

This clinical event record also appears under Immunology and Infectious Diseases:





11.1.7 Genito-urinary Cancer

There are no Genito-urinary Cancer specific clinical records.

11.1.8 Skin Cancer

There are no Skin Cancer specific clinical records.

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11.1.9 Upper Gastrointestinal Cancer

There are no Gastrointestinal Cancer specific clinical records.

11.1.10 Head and Neck Cancer

There are no Head and Neck Cancer specific clinical records.

11.1.11 Central Nervous System Cancer

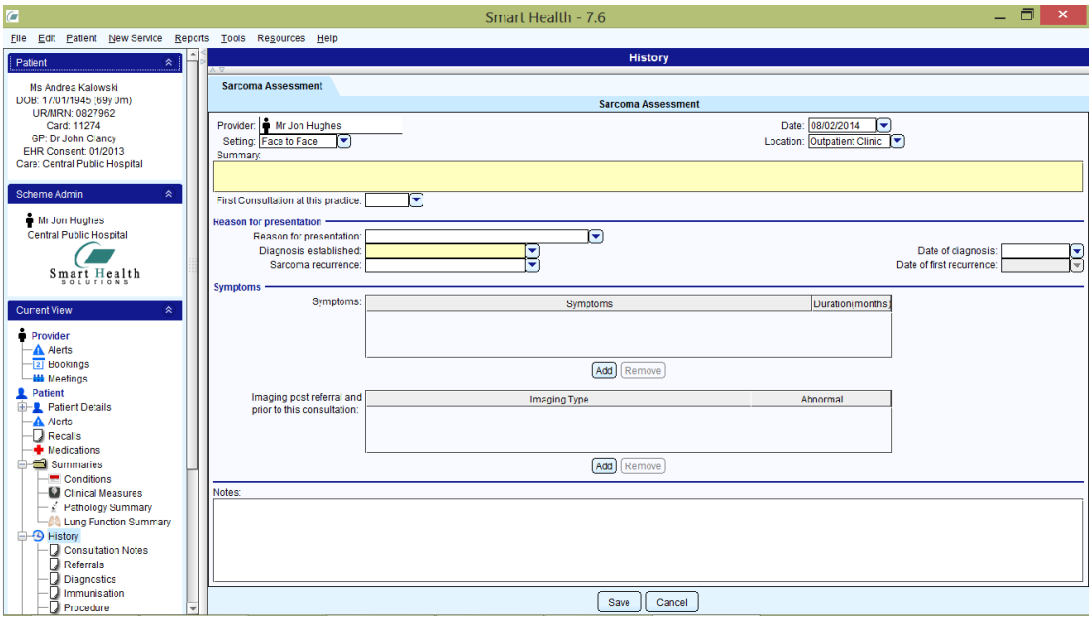
There are no Central Nervous System Cancer specific clinical records.

11.1.12 Haematology

There are no Haematology specific clinical records.

11.1.13 Sarcoma

11.1.13.1 Sarcoma Assessment



11.2 Cystic Fibrosis

The Cystic Fibrosis program contains a set of forms to capture data for Cystic Fibrosis Clinics, various allied health assessments, Cystic Fibrosis letters to referring providers, Cystic Fibrosis Care Plans and Cystic Fibrosis Australia reporting.

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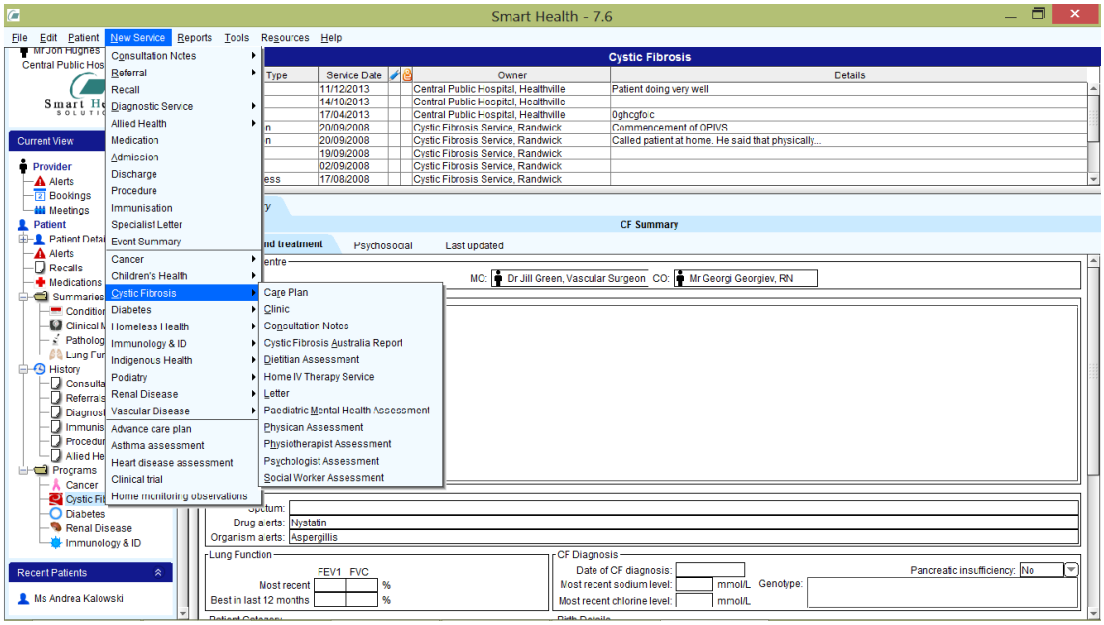
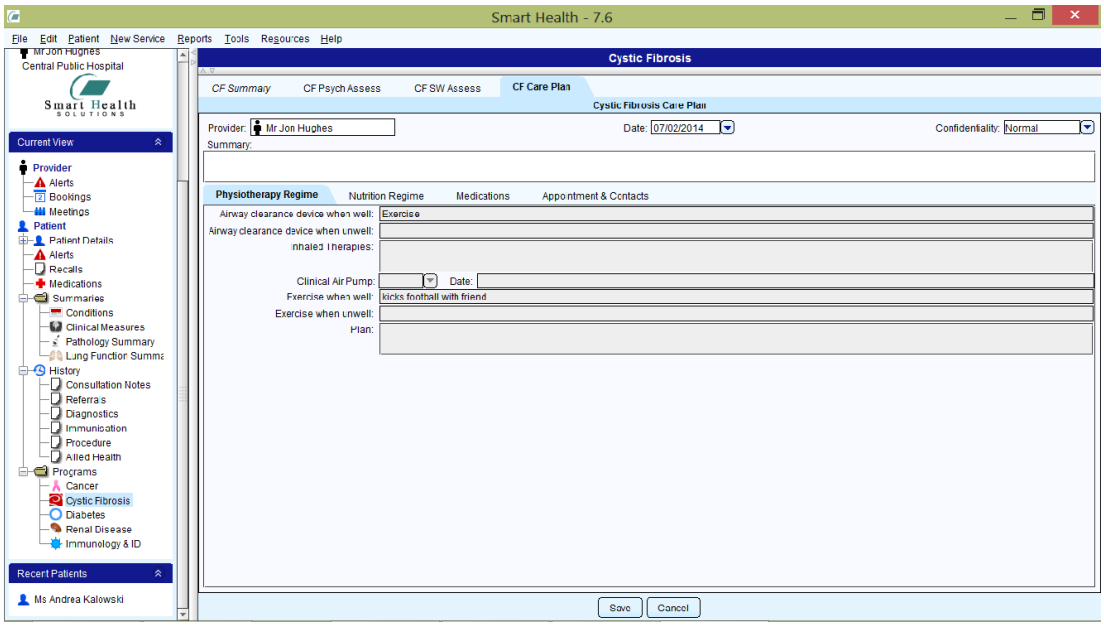
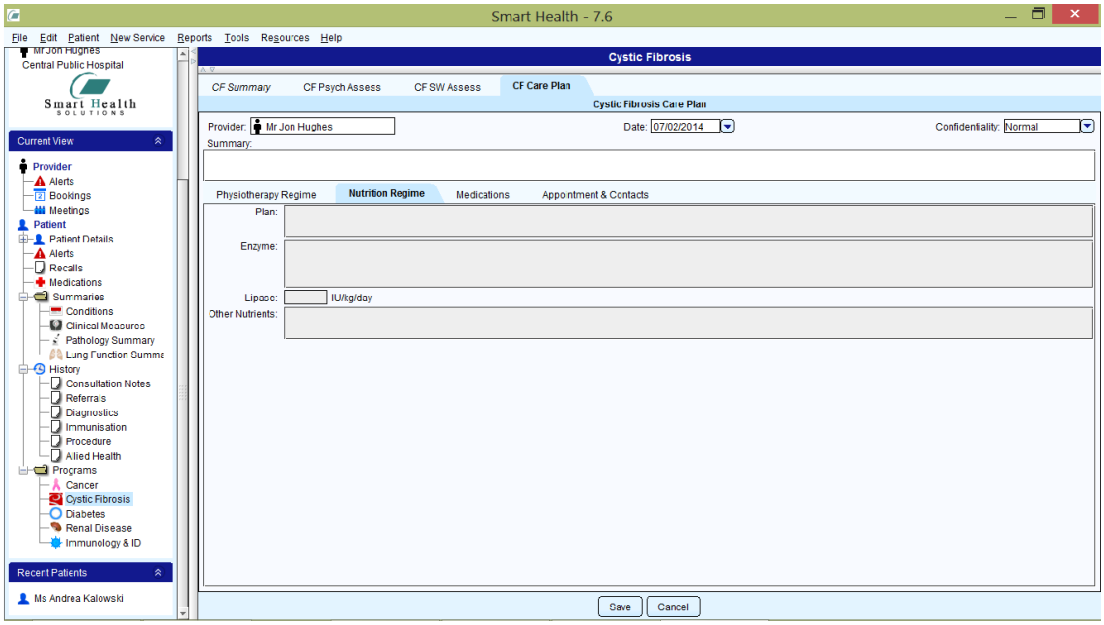


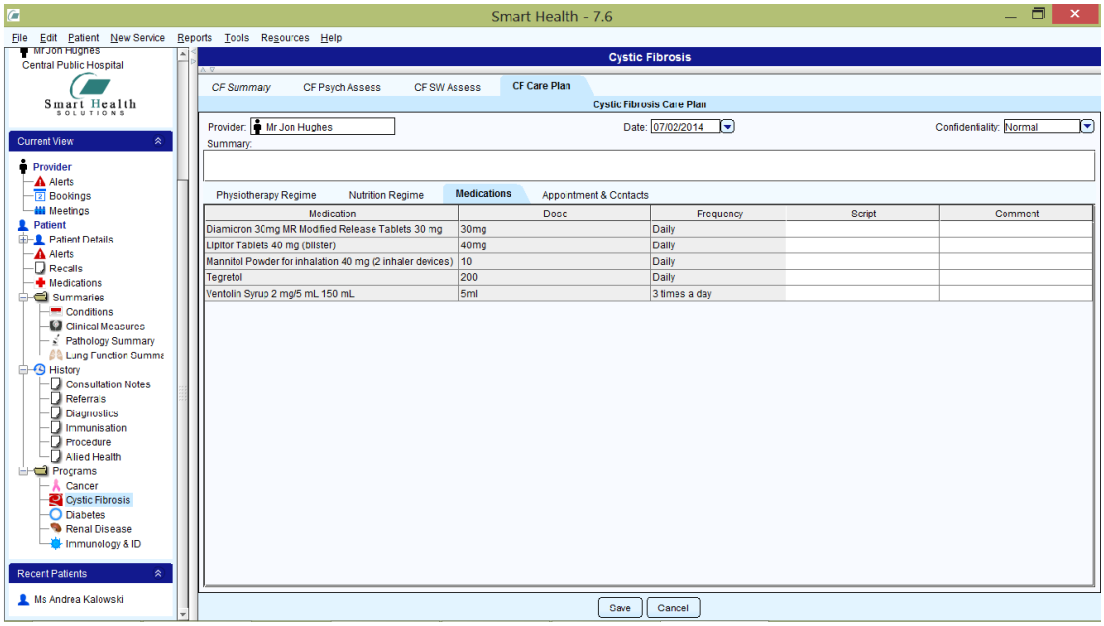
11.2.1 CF Care Plan

The CF Care Plan is designed to present key self-management information for patients. It can be printed to hand to the patient and viewed on-line.

Most of the data is taken from other CF forms and is read only.




Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Mr Jon Hughes
Central Public Hospital
Smart Health SOLUTIONS
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Programs
Cancer
Cystic Fibrosis
Diabetes
Renal Disease
Immunology & ID
Recent Patients
Ms Andrea Kalowski
Cystic Fibrosis
CF Summary
CF Psych Assess
CF SW Assess
CF Care Plan
Cystic Fibrosis Care Plan
Provider: Mr Jon Hughes
Date: 07/02/2014
Confidentiality: Normal
Summary:
Physiotherapy Regime
Nutrition Regime
Medications
Appointment & Contacts
Plan:
Enzyme:
Lipase:
IU/kg/day
Other Nutrients:
Save
Cancel


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Mr Jon Hughes
Central Public Hospital
Smart Health SOLUTIONS
Current View
Provider
Alerts
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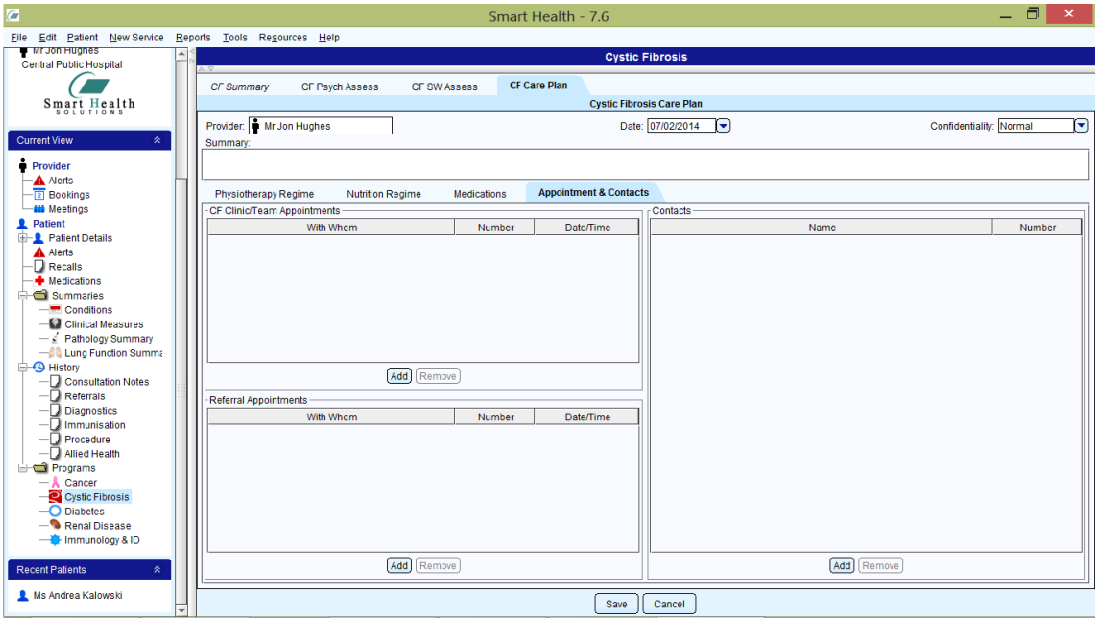
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Programs
Cancer
Cystic Fibrosis
Diabetes
Renal Disease
Immunology & ID
Recent Patients
Ms Andrea Kalowski
Cystic Fibrosis
CF Summary
CF Psych Assess
CF SW Assess
CF Care Plan
Cystic Fibrosis Care Plan
Provider: Mr Jon Hughes
Date: 07/02/2014
Confidentiality: Normal
Summary:
Physiotherapy Regime
Nutrition Regime
Medications
Appointment & Contacts
Medication
Dose
Frequency
Script
Comment
Diamicron 30mg MR Modified Release Tablets 30 mg
30mg
Daily
Lipitor Tablets 40 mg (blister)
40mg
Daily
Mannitol Powder for inhalation 40 mg (2 inhaler devices)
10
Daily
Tegretol
200
Daily
Ventolin Syrup 2 mg/5 mL 150 mL
5ml
3 times a day
Save
Cancel



11.2.2 CF Clinic

The Cystic Fibrosis Clinic record has a tab for each discipline that the patient consults, plus General, Assessment and Review tabs. Only one record can be created for a clinic date. The first user to record information for the patient's clinic day will create the new clinic record, which will then be updated by each provider that treats the patient. If a user attempts to create a new clinic record and one already exists for the selected date, the existing record will be opened.

Several providers can open and update the same clinical record simultaneously, although they will not see their colleagues' updates until the patient record is closed and re-opened.

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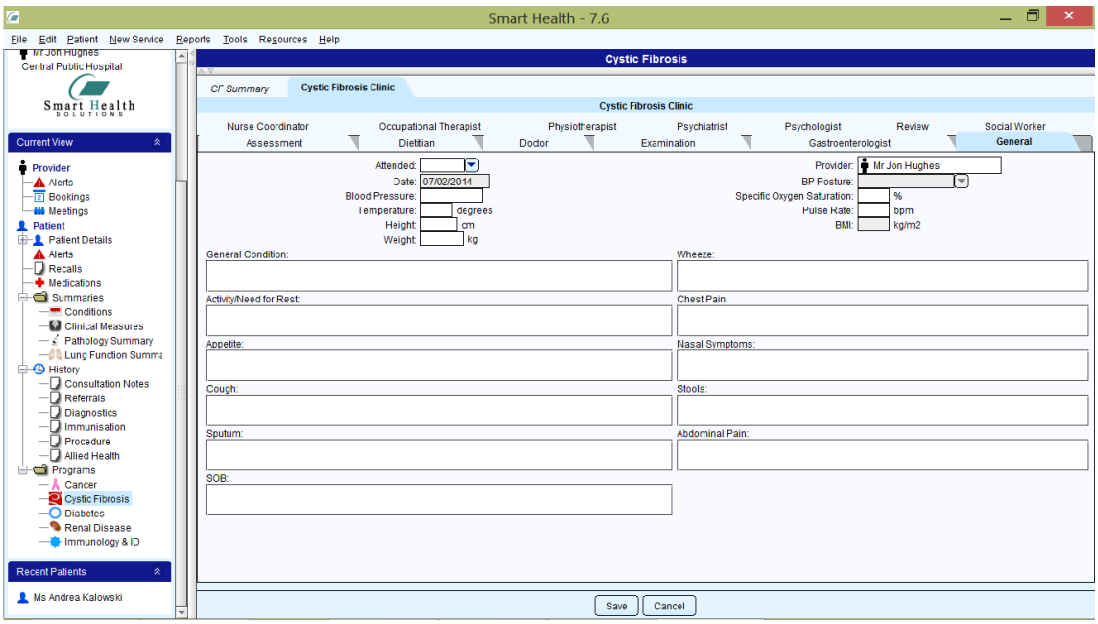
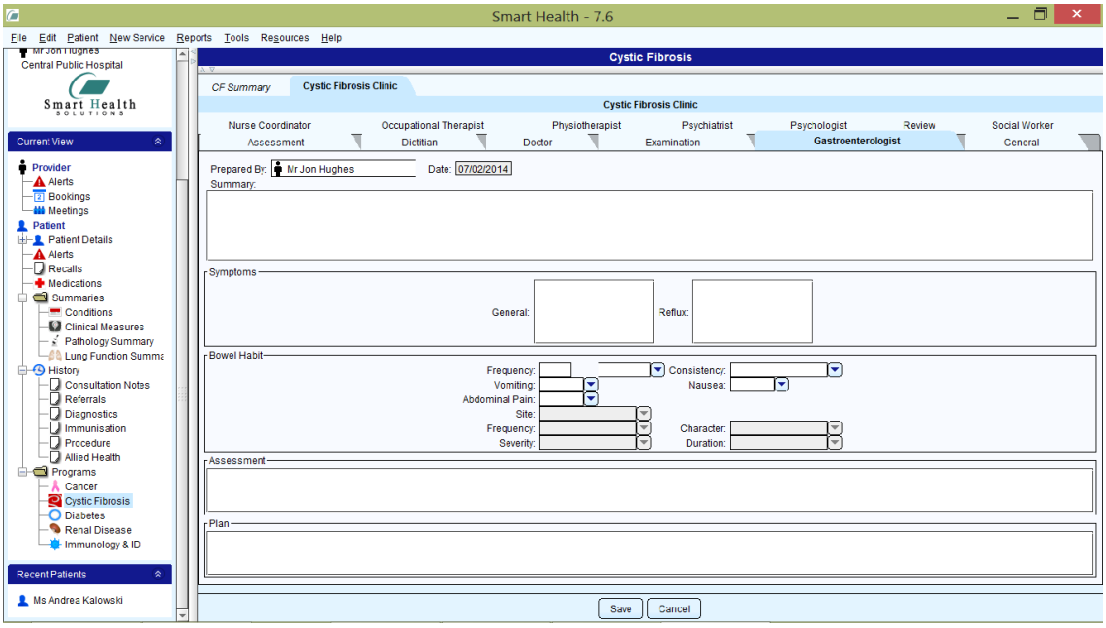
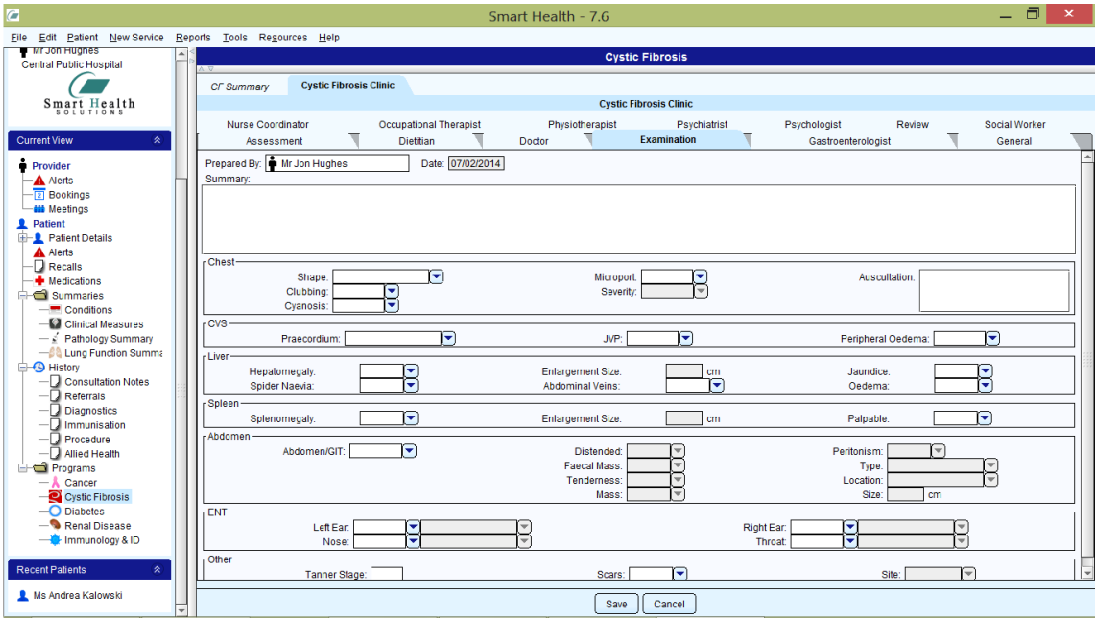
11.2.2.1 General



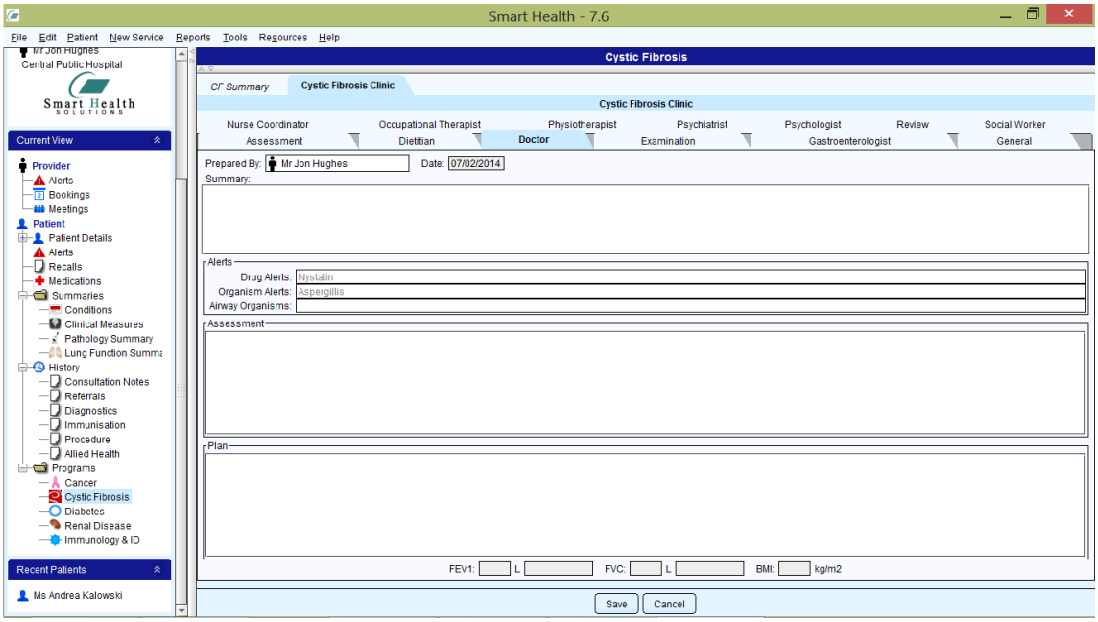
11.2.2.2 Gastroenterologist



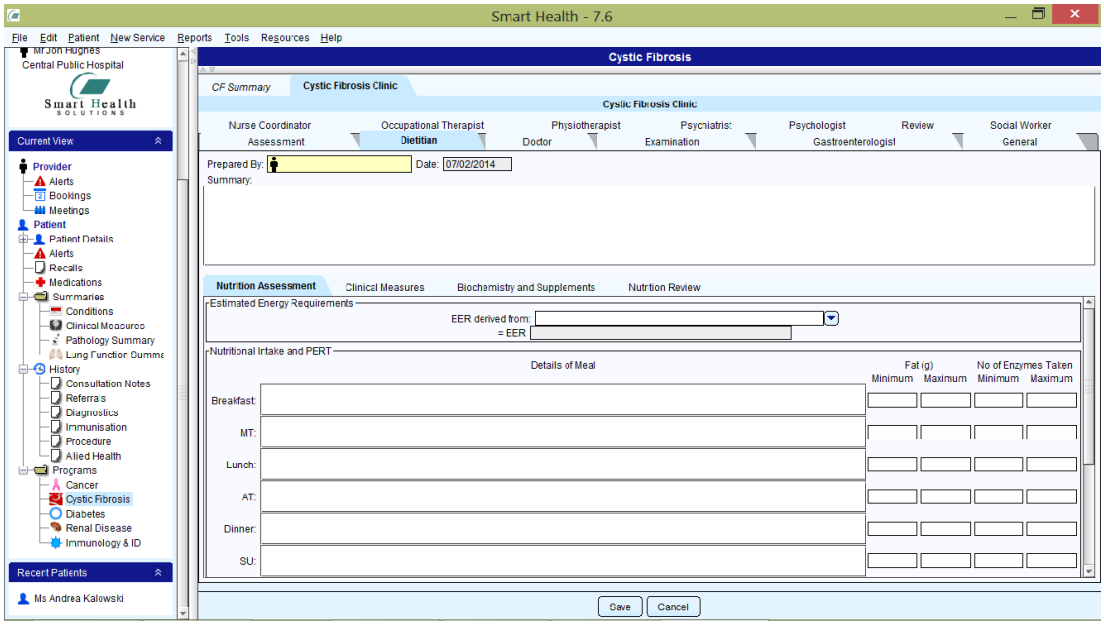
11.2.2.3 Examination



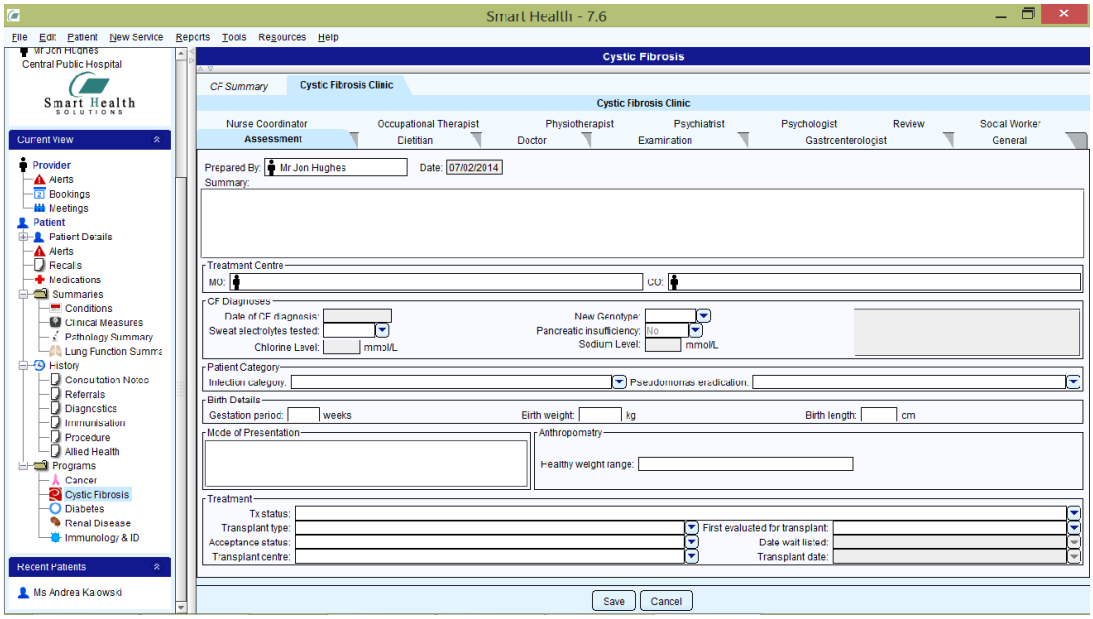
11.2.2.4 Doctor



11.2.2.5 Dietitian



11.2.2.6 Assessment



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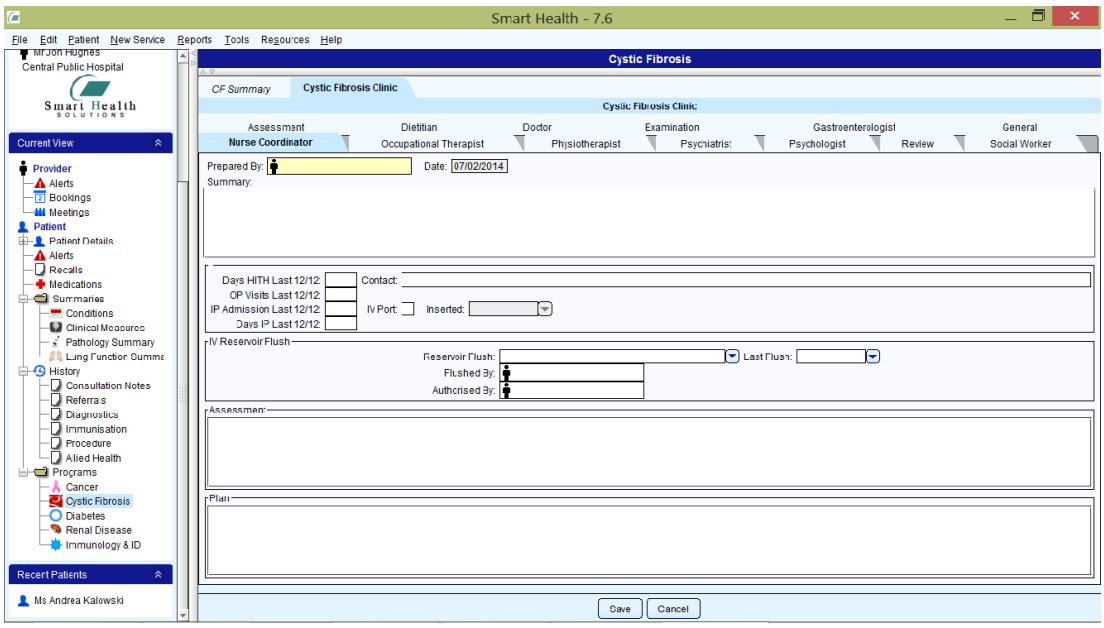

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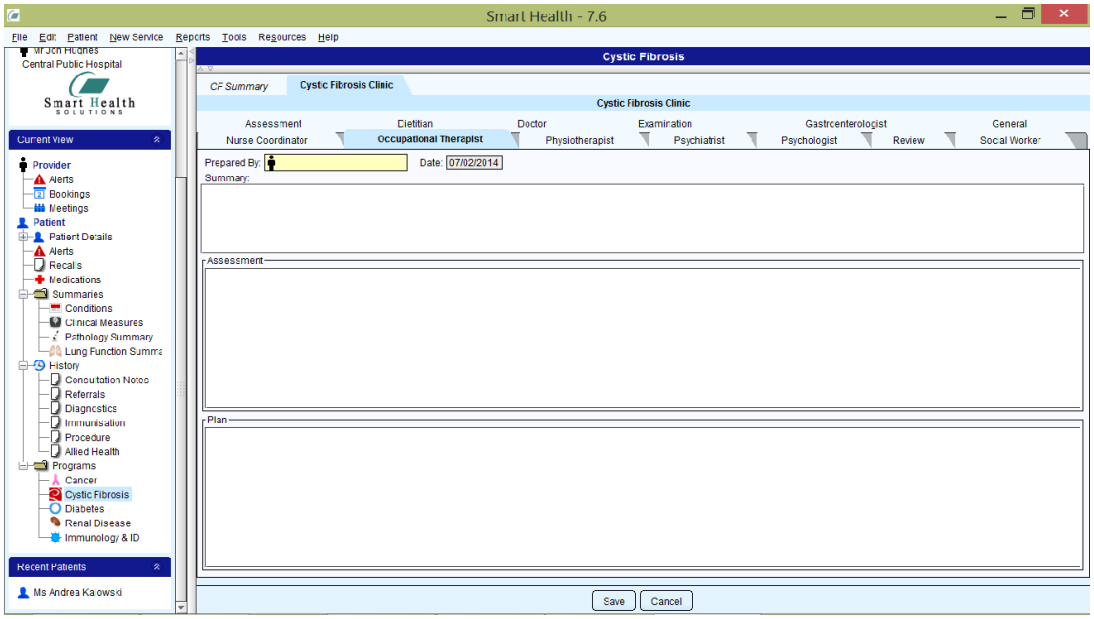
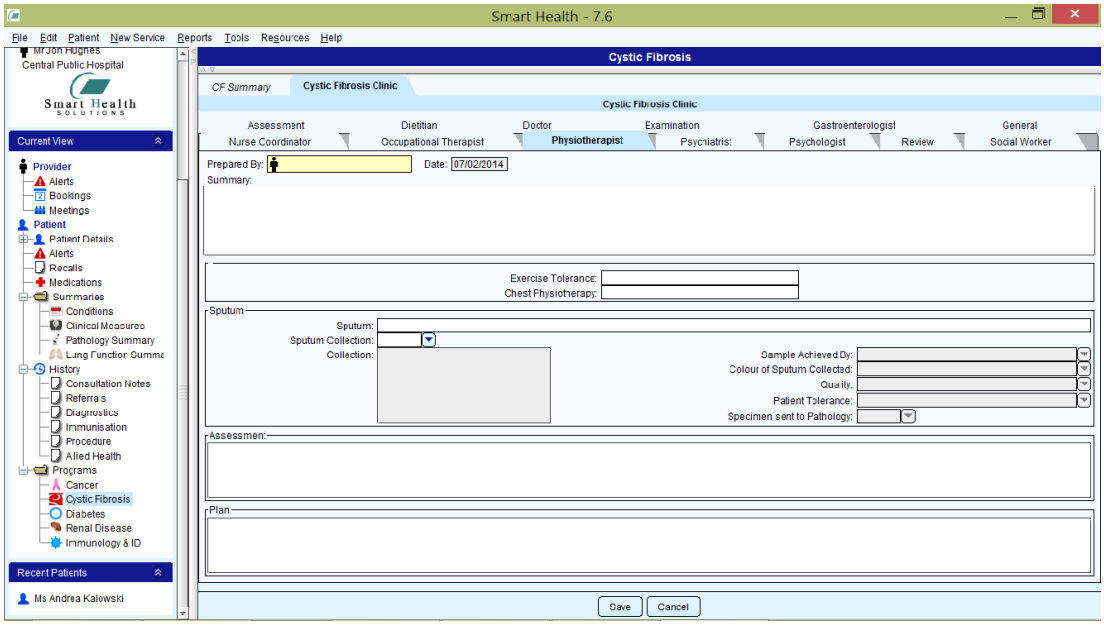


11.2.2.9 Physiotherapist



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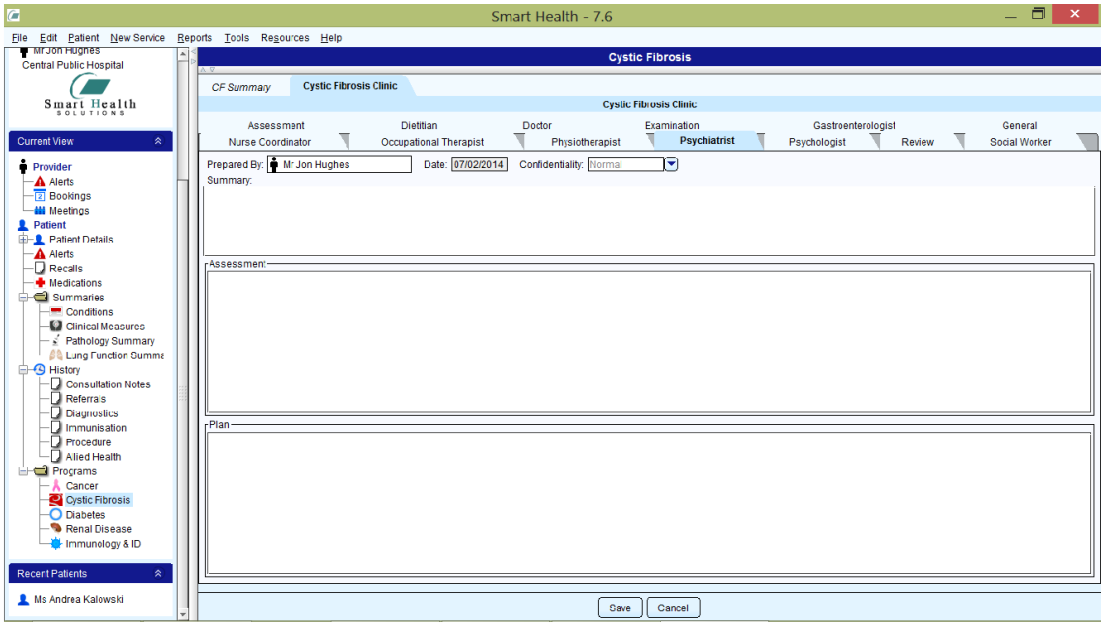
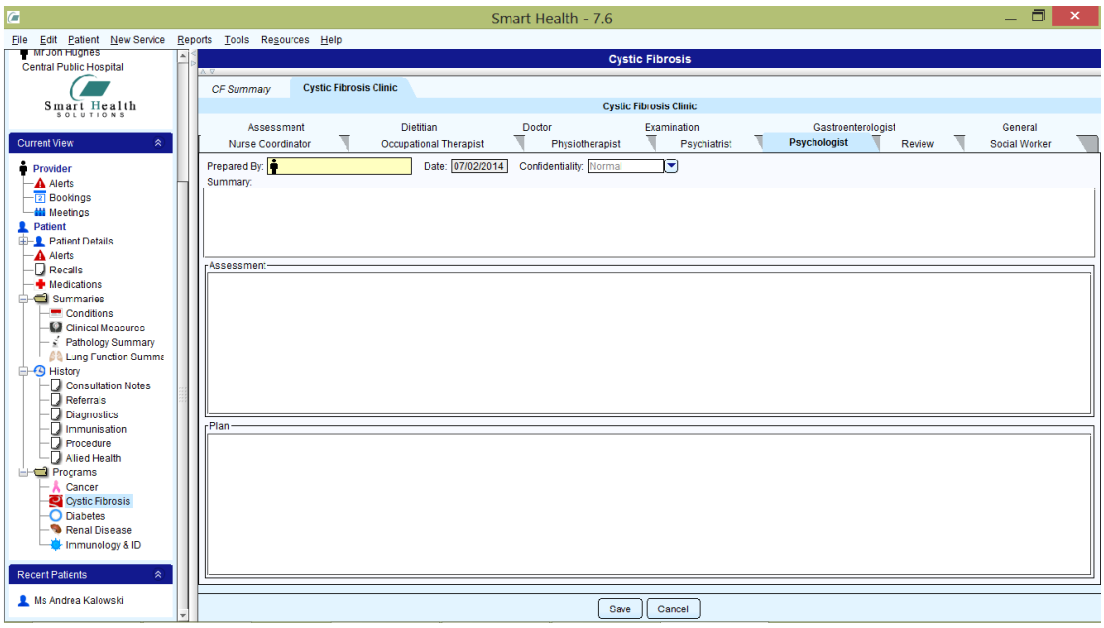
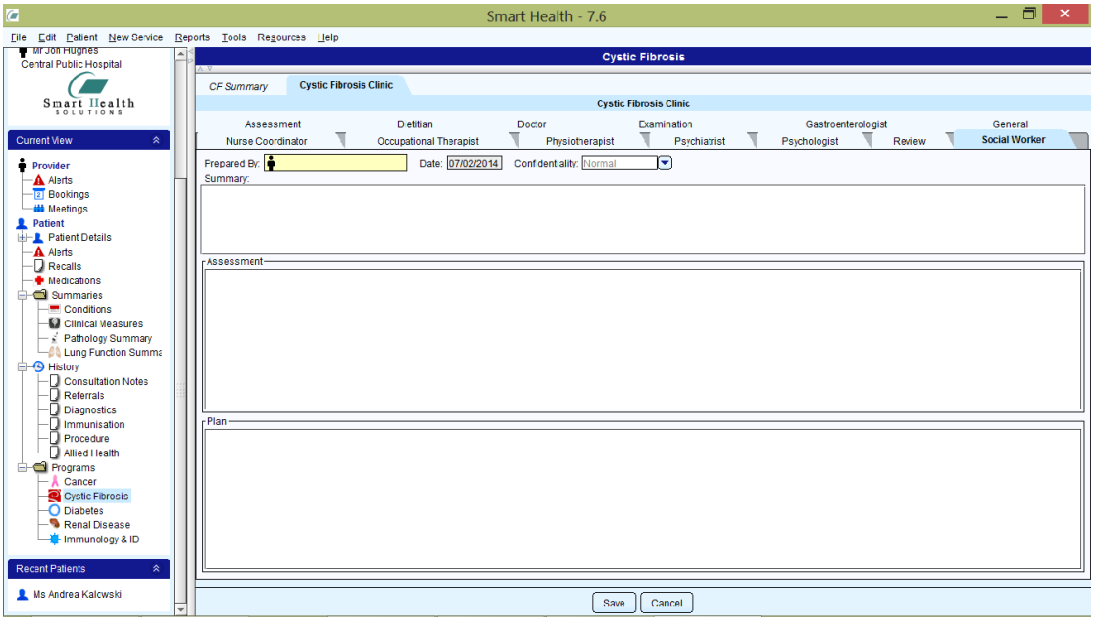


11.2.2.11 Psychologist



11.2.2.12 Social Worker



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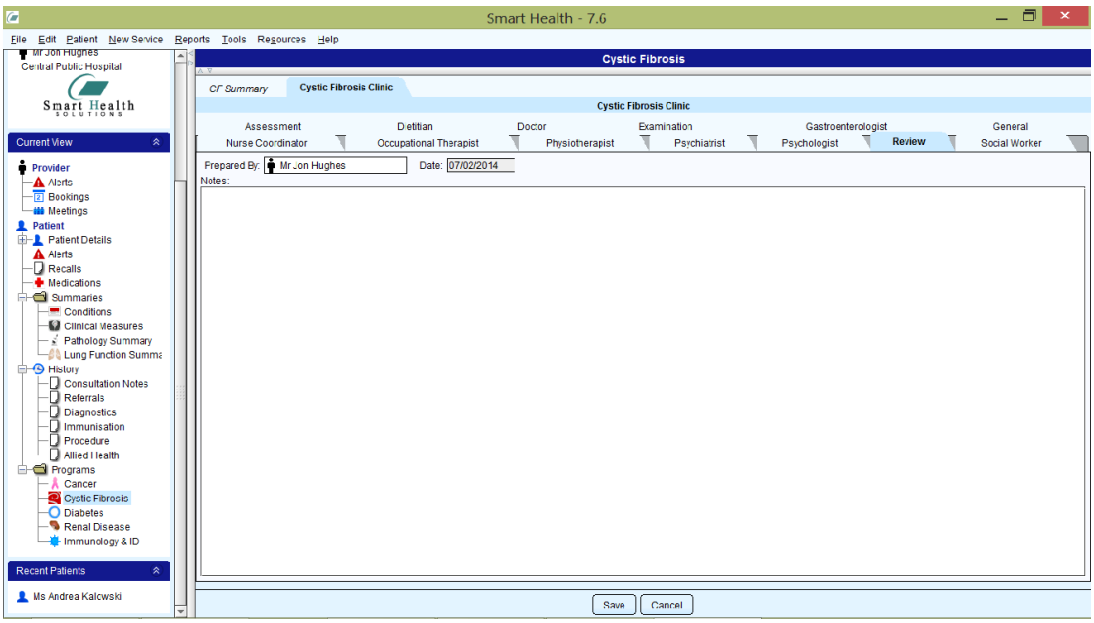
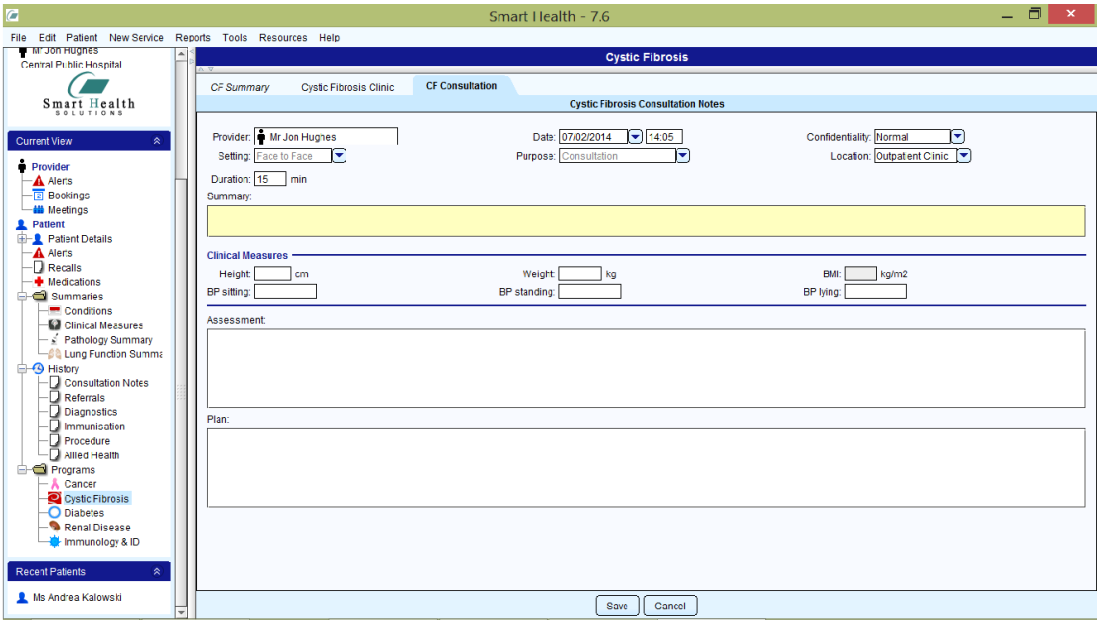
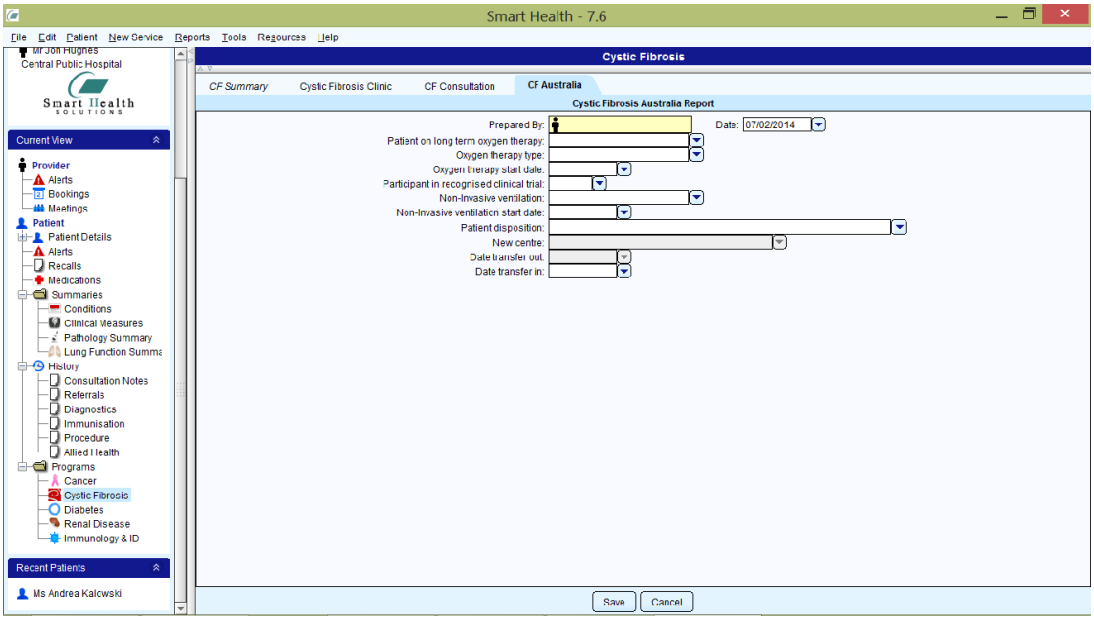


11.2.3 CF Consultation Note



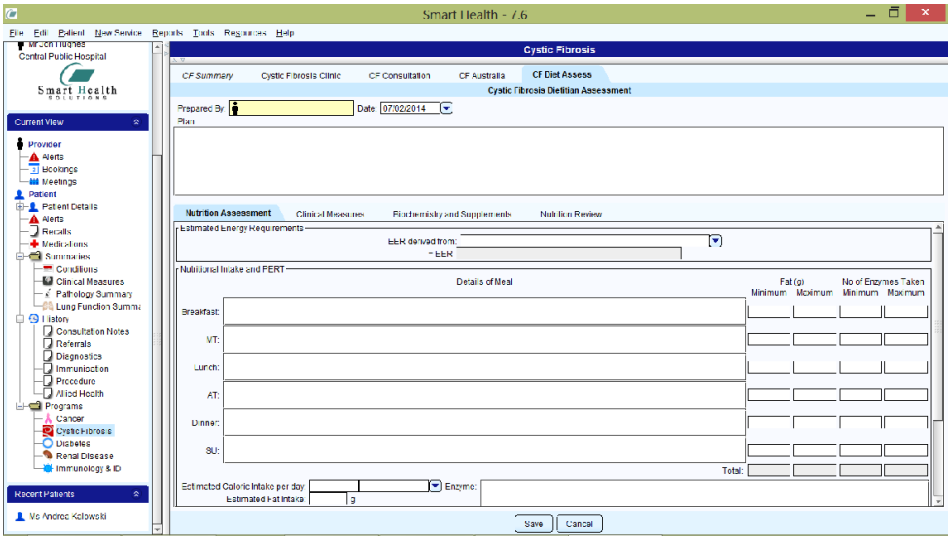
11.2.4 CF Australia

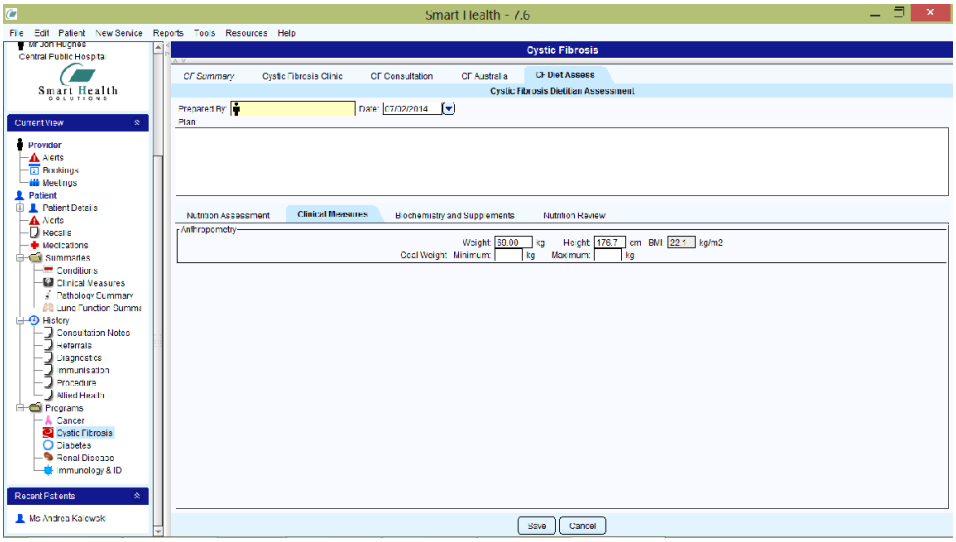
The CF Australia record captures CF Australia Database information that is not recorded elsewhere in the Smart Health application.

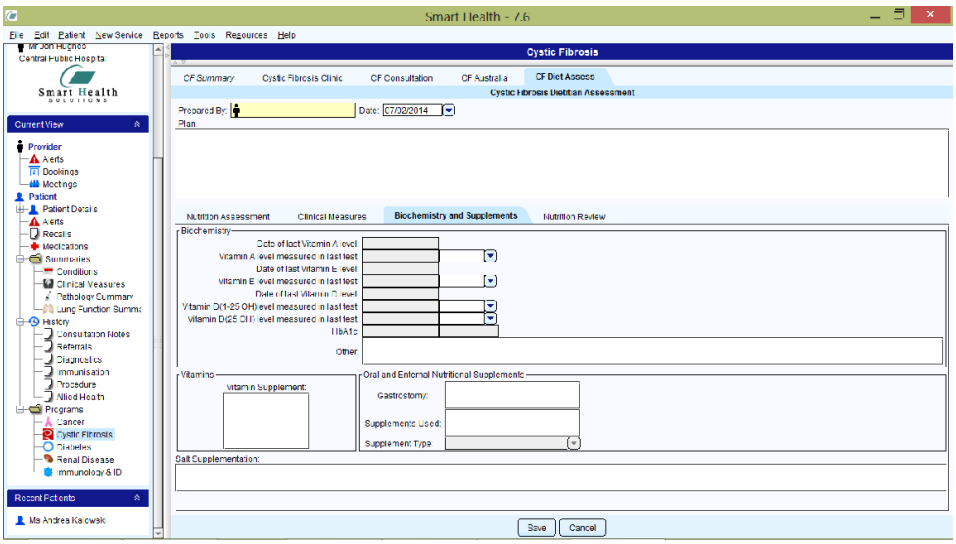


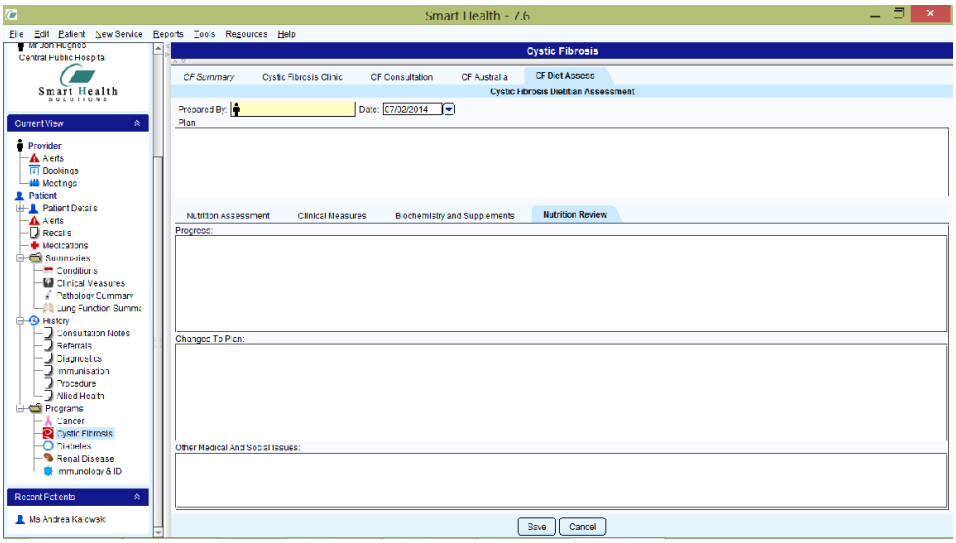
When a CF Australia record has been completed for each patient, Smart Health can generate an electronic CF Australia reporting file for the whole practice (CF Service).

11.2.5 CF Dietitian Assessment




Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Cystic Fibrosis
CF Summary
Cystic Fibrosis Clinic
CF Consultation
CF Australia
CF Diet Assess
Cystic Fibrosis Dietitian Assessment
Prepared By:
Date: 07/02/2014
Plan
Nutrition Assessment
Clinical Measures
Biochemistry and Supplements
Nutrition Review
Anthropometry
Weight: 80.00 kg
Height: 176.7 cm
BMI: 22.1 kg/m2
Usual Weight: Minimum: kg
Maximum: kg
Save
Cancel


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Cystic Fibrosis
CF Summary
Cystic Fibrosis Clinic
CF Consultation
CF Australia
CF Diet Assess
Cystic Fibrosis Dietitian Assessment
Prepared By:
Date: 07/02/2014
Plan
Nutrition Assessment
Clinical Measures
Biochemistry and Supplements
Nutrition Review
Biochemistry
Date of last Vitamin A level
Vitamin A level measured in last test
Date of last vitamin E level
Vitamin E level measured in last test
Date of last Vitamin D level
Vitamin D(1-25 OH) level measured in last test
Vitamin D(25 OH) level measured in last test
HbA1c
Other
Vitamins
Vitamin Supplement:
Oral and Enteral Nutritional Supplements
Gastrostomy:
Supplements Used:
Supplement Type:
Salt Supplementation:
Save
Cancel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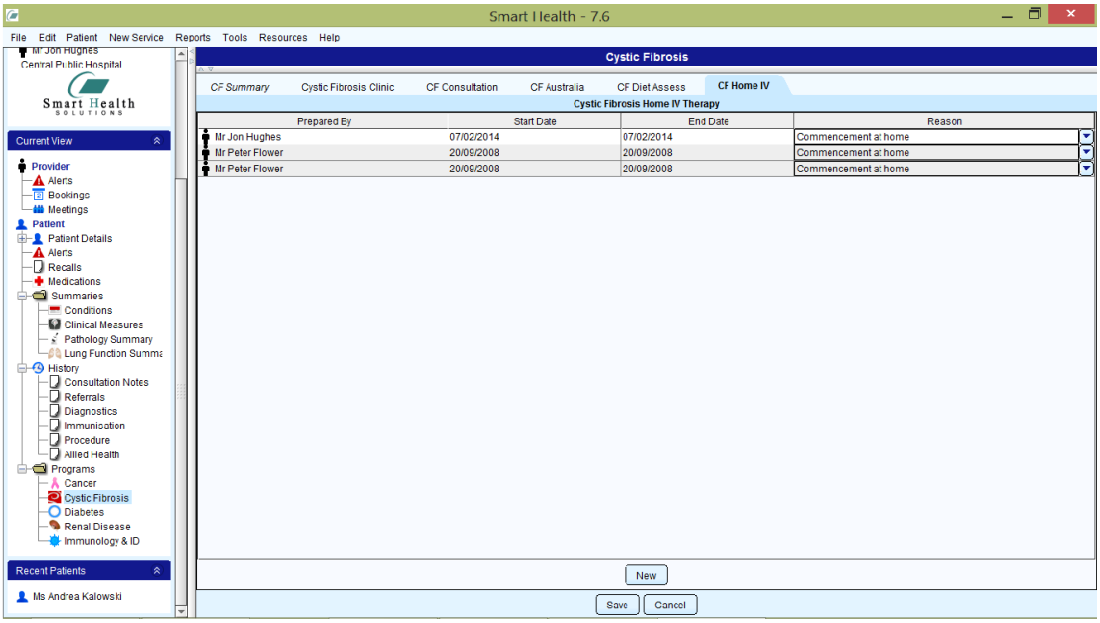
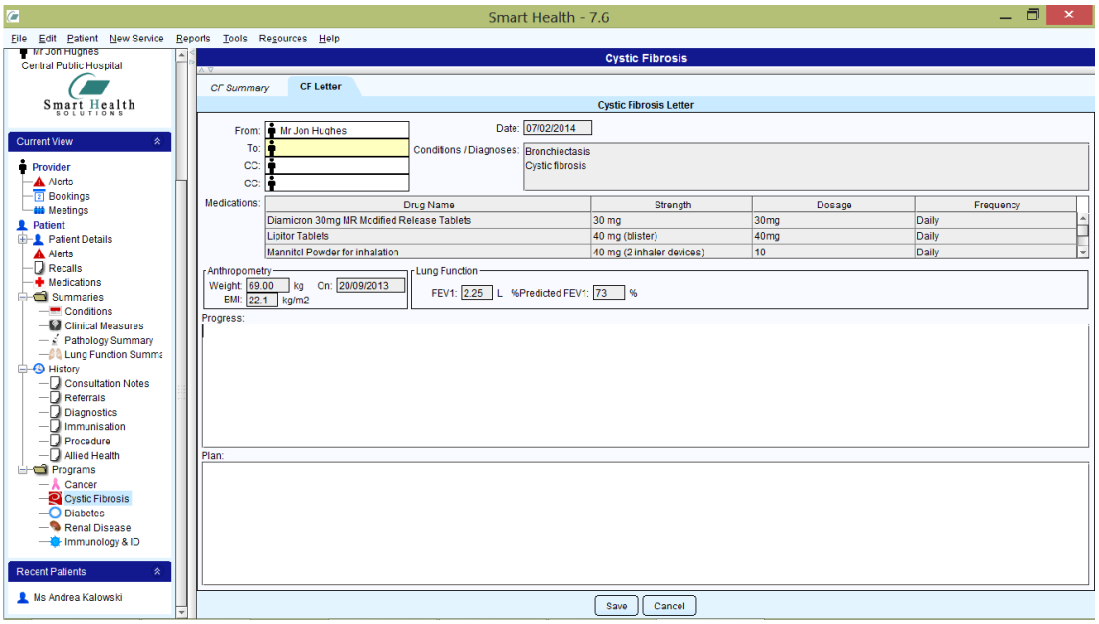
Cystic Fibrosis
CF Summary
Cystic Fibrosis Clinic
CF Consultation
CF Australia
CF Diet Assess
Cystic Fibrosis Dietitian Assessment
Prepared By:
Date: 07/02/2014
Plan
Nutrition Assessment
Clinical Measures
Biochemistry and Supplements
Nutrition Review
Progress:
Changes To Plan:
Other Medical And Social Issues:
Save
Cancel

11.2.6 CF Home IV Therapy



11.2.7 CF Letter

The CF Letter is designed to aggregate information from the patient record, including diagnoses, medications, clinical measures, lung function, etc. and to present it in a format suitable for a letter that will be sent to external healthcare providers. Users can enter text that is specific to each instance of the letter.



When the Letter is saved, it can be printed as a ".pdf" file and emailed to referring providers, printed and handed to the patient or posted - and also viewed on-line.

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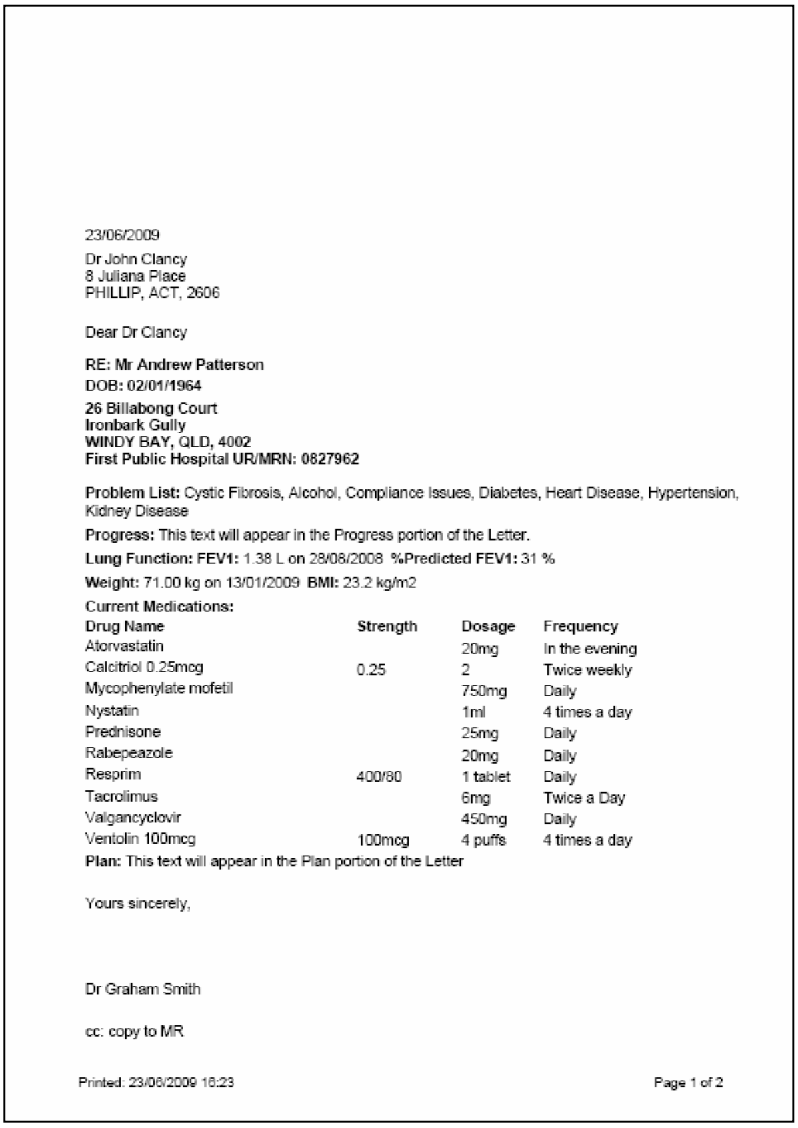


23/06/2009

Dr John Clancy
8 Juliana Place
PHILLIP, ACT, 2606

Dear Dr Clancy

RE: Mr Andrew Patterson
DOB: 02/01/1964
26 Billabong Court
Ironbark Gully
WINDY BAY, QLD, 4002
First Public Hospital UR/MRN: 0827962

Problem List: Cystic Fibrosis, Alcohol, Compliance Issues, Diabetes, Heart Disease, Hypertension, Kidney Disease

Progress: This text will appear in the Progress portion of the Letter.

Lung Function: FEV1: 1.38 L on 28/08/2008 **%Predicted FEV1:** 31 %

Weight: 71.00 kg on 13/01/2009 **BMI:** 23.2 kg/m2

Current Medications:

Drug Name	Strength	Dosage	Frequency
Atorvastatin		20mg	In the evening
Calcitriol 0.25mcg	0.25	2	Twice weekly
Mycophenylate mofetil		750mg	Daily
Nystatin		1ml	4 times a day
Prednisone		25mg	Daily
Rabepeazole		20mg	Daily
Resprim	400/80	1 tablet	Daily
Tacrolimus		6mg	Twice a Day
Valgancyclovir		450mg	Daily
Ventolin 100mcg	100mcg	4 puffs	4 times a day

Plan: This text will appear in the Plan portion of the Letter

Yours sincerely,

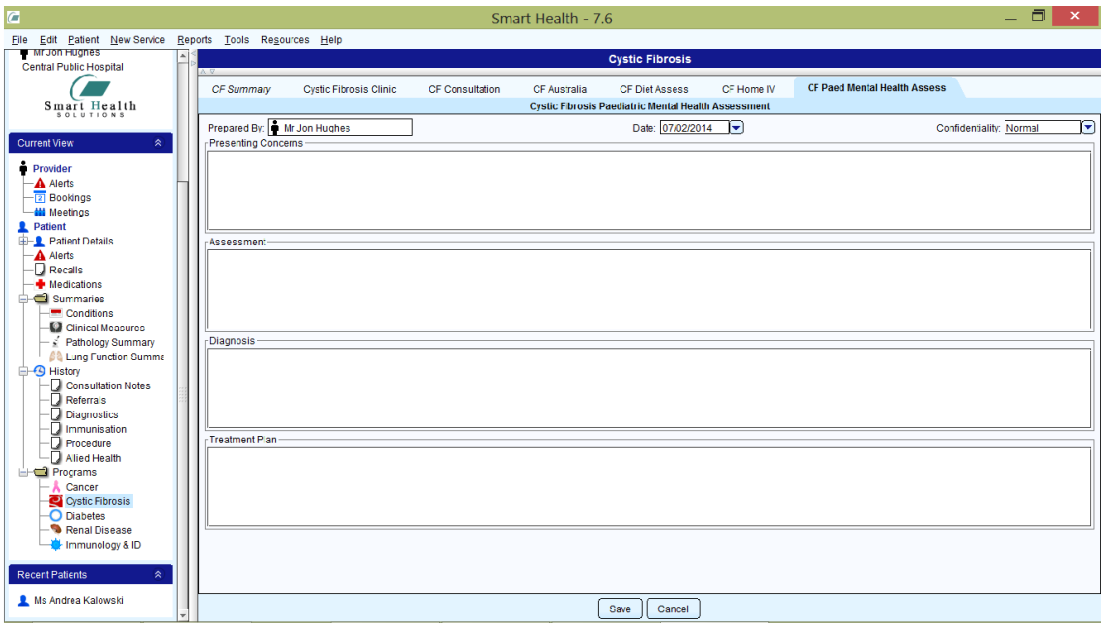
Dr Graham Smith

cc: copy to MR

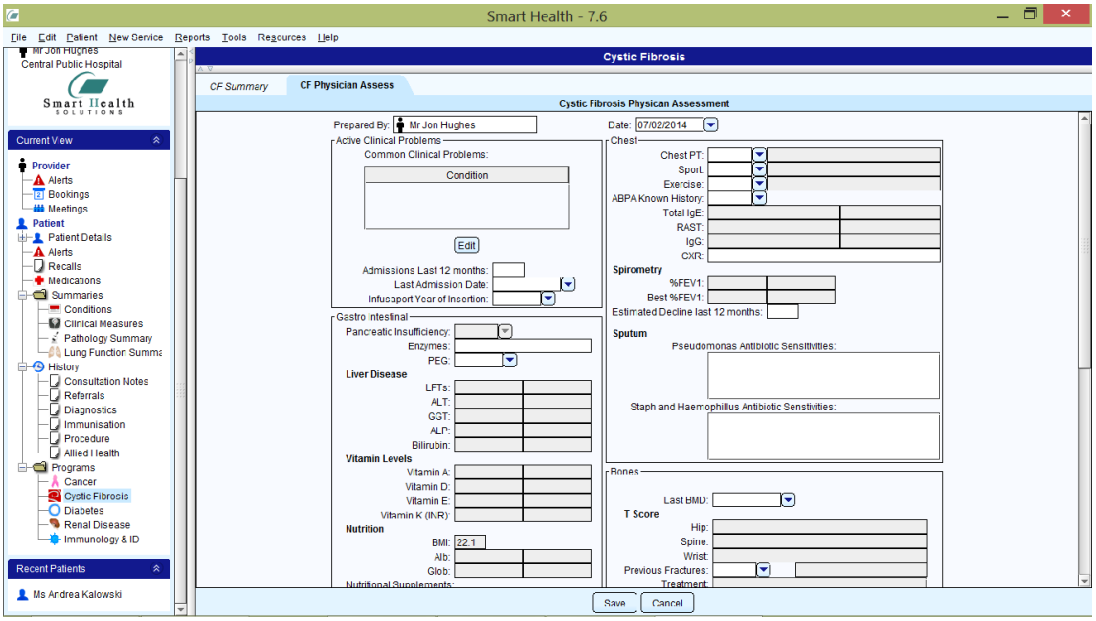
Printed: 23/06/2009 16:23

Page 1 of 2

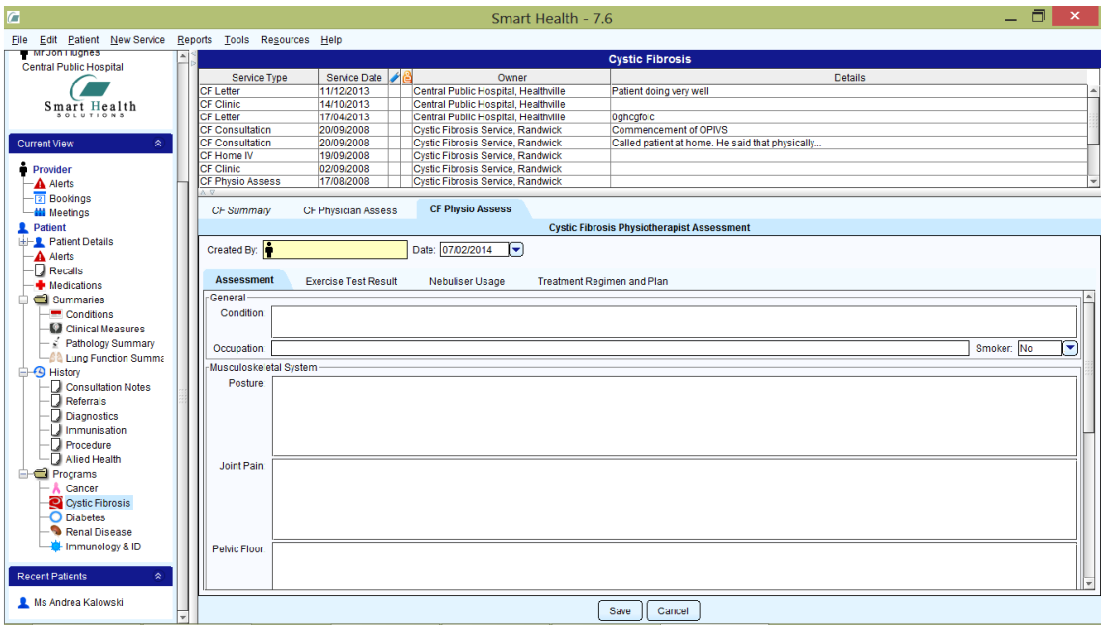
11.2.8 CF Paediatric Mental Health Assessment

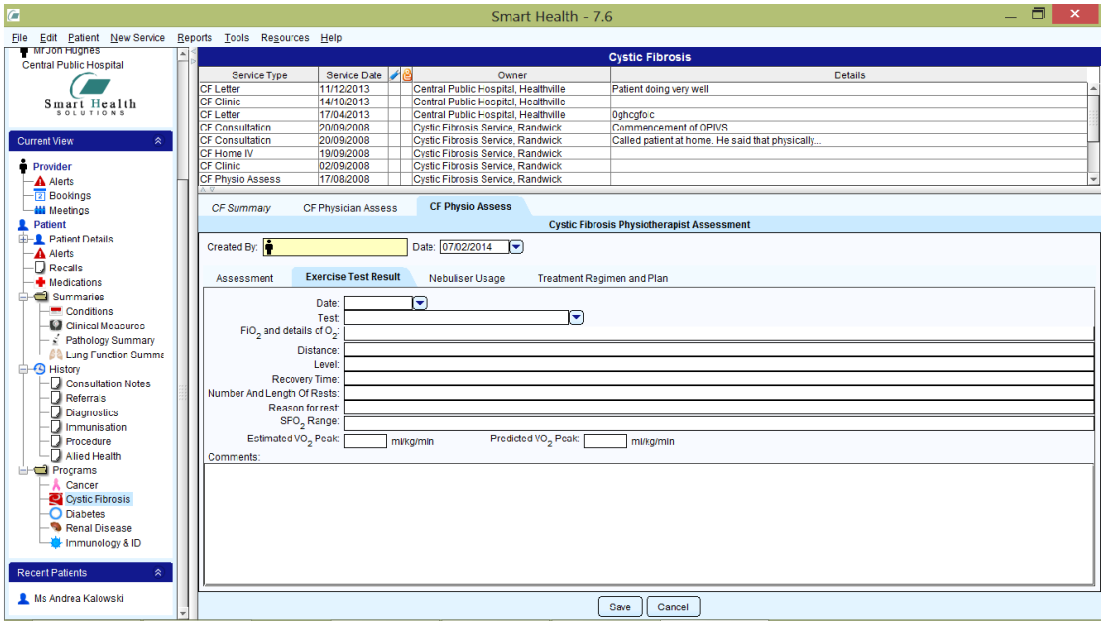


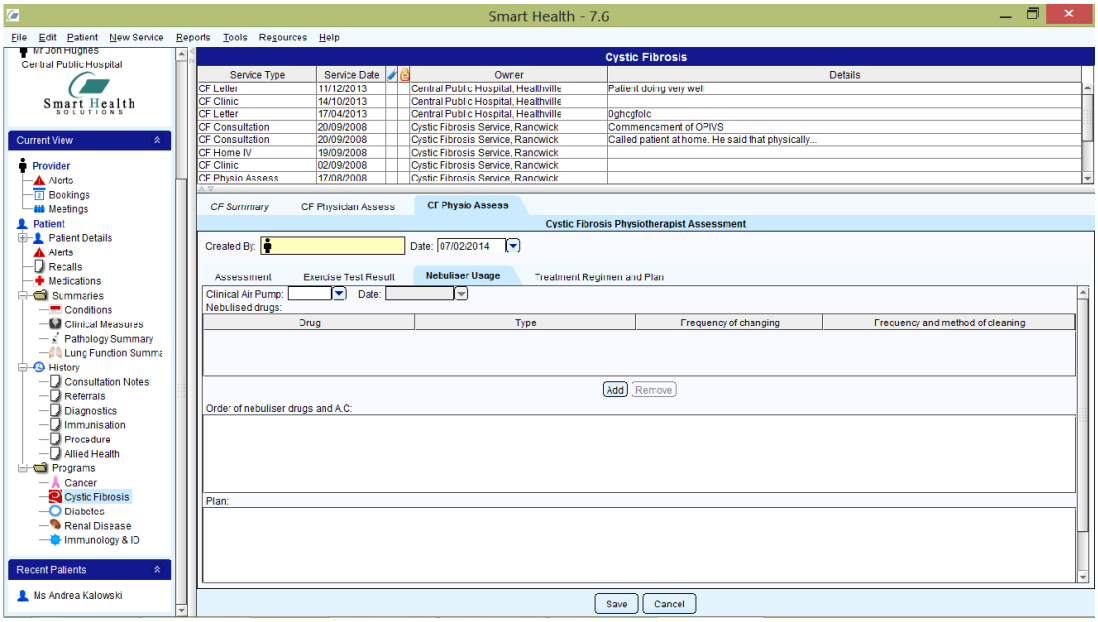
11.2.9 Physician Assessment



11.2.10 Physiotherapist Assessment'






Smart Health - 7.6
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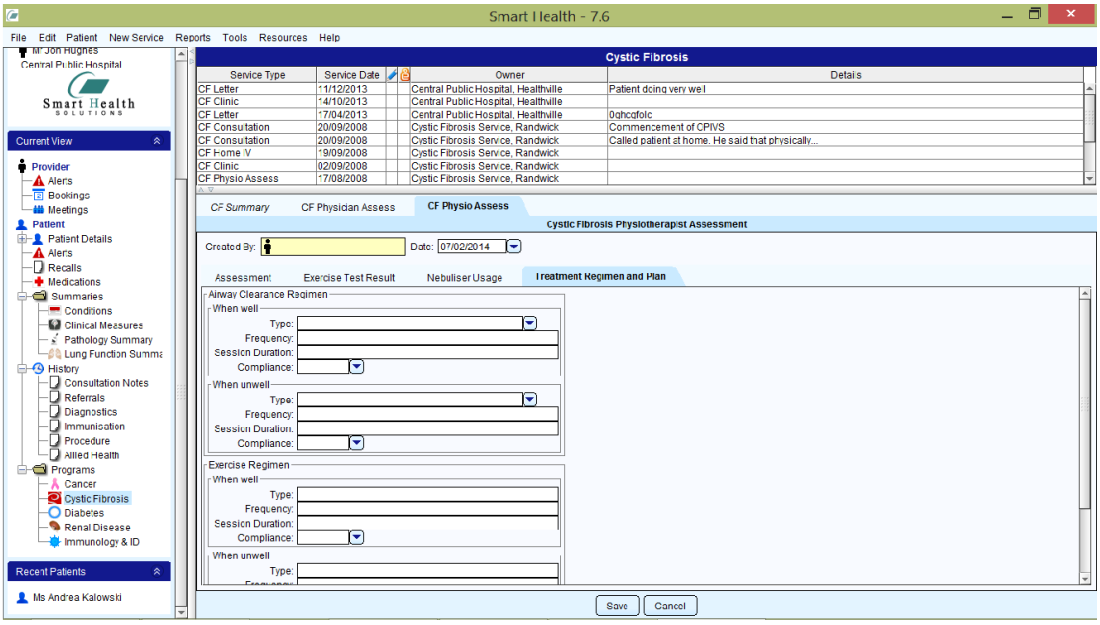
Central Public Hospital
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Pathology Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Programs
Cancer
Cystic Fibrosis
Diabetes
Renal Disease
Immunology & ID
Recent Patients
Ms Andrea Kalowski
Cystic Fibrosis
Service Type
Service Date
Owner
Details
CF Letter 11/12/2013 Central Public Hospital, Healthville Patient doing very well
CF Clinic 14/10/2013 Central Public Hospital, Healthville
CF Letter 17/04/2013 Central Public Hospital, Healthville 0ghcgfolc
CF Consultation 20/09/2008 Cystic Fibrosis Service, Randwick Commencement of OPIVS
CF Consultation 20/09/2008 Cystic Fibrosis Service, Randwick Called patient at home. He said that physically...
CF Home IV 19/09/2008 Cystic Fibrosis Service, Randwick
CF Clinic 02/09/2008 Cystic Fibrosis Service, Randwick
CF Physio Assess 17/08/2008 Cystic Fibrosis Service, Randwick
CF Summary
CF Physician Assess
CF Physio Assess
Cystic Fibrosis Physiotherapist Assessment
Created By:
Date: 07/02/2014
Assessment
Exercise Test Result
Nebuliser Usage
Treatment Regimen and Plan
Clinical Air Pump:
Date:
Nebulised drugs:
Drug
Type
Frequency of changing
Frecuency and method of cleaning
Add
Remove
Order of nebuliser drugs and A.C:
Plan:
Save
Cancel


Smart Health - 7.6
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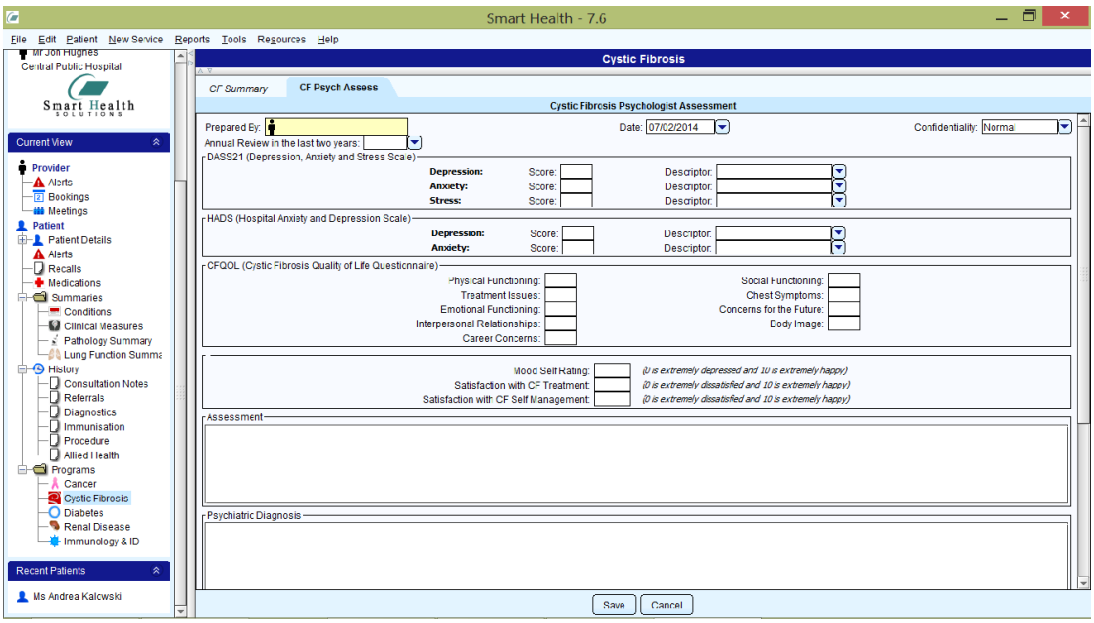
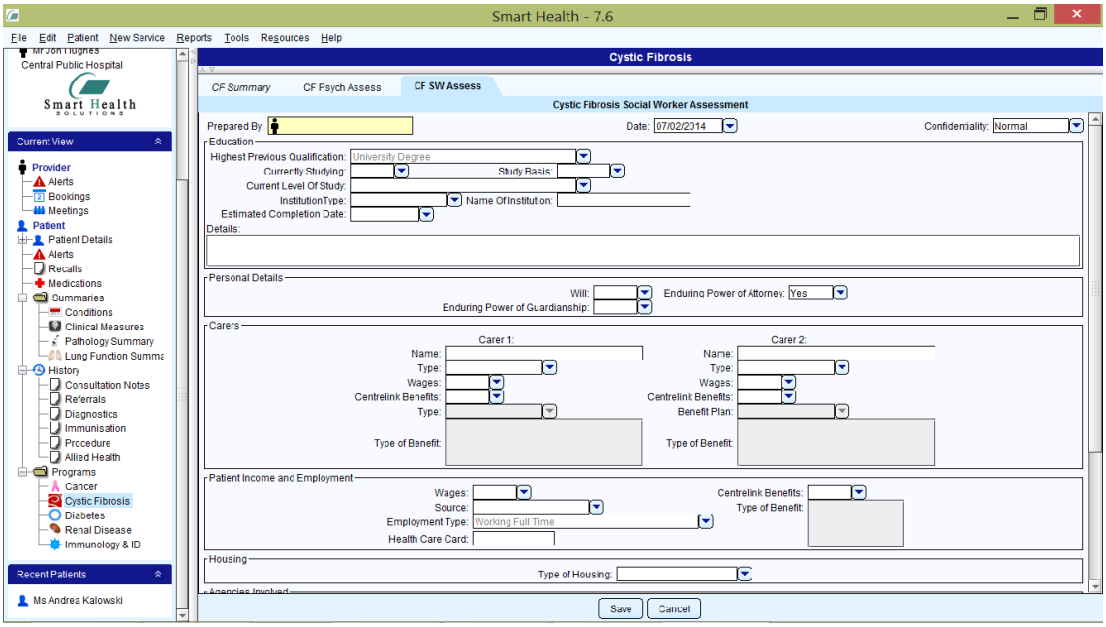
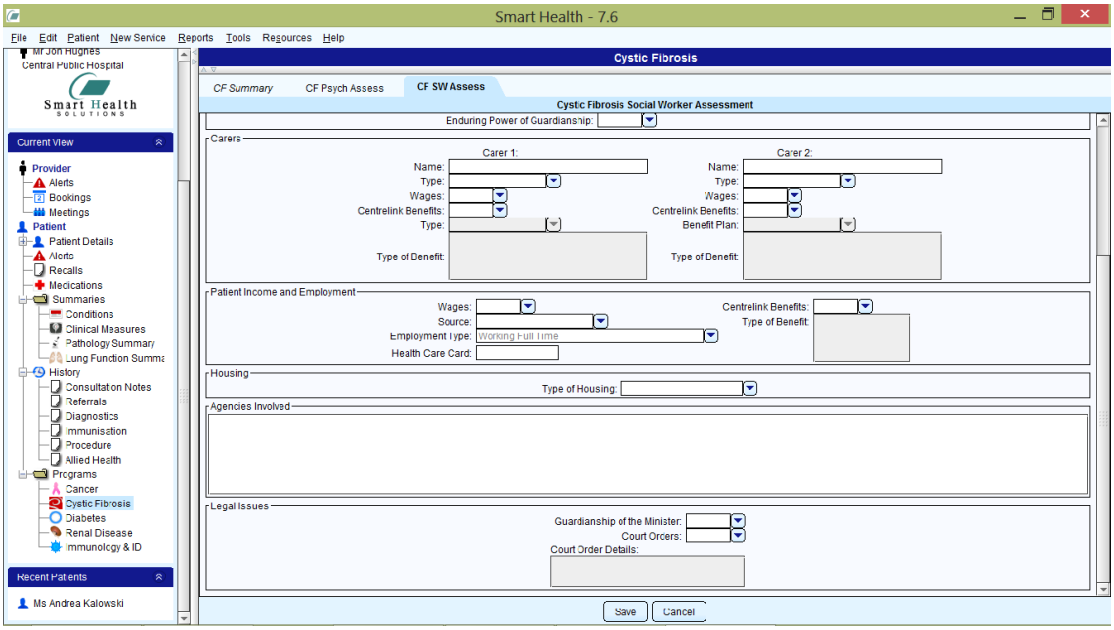
CF Clinic 02/09/2008 Cystic Fibrosis Service, Randwick
CF Physio Assess 17/08/2008 Cystic Fibrosis Service, Randwick
CF Summary
CF Physician Assess
CF Physio Assess
Cystic Fibrosis Physiotherapist Assessment
Created By:
Date: 07/02/2014
Assessment
Exercise Test Result
Nebuliser Usage
Treatment Regimen and Plan
Airway Clearance Regimen
When well
Type:
Frequency:
Session Duration:
Compliance:
When unwell
Type:
Frequency:
Session Duration:
Compliance:
Exercise Regimen
When well
Type:
Frequency:
Session Duration:
Compliance:
When unwell
Type:
Save
Cancel

11.2.11 CF Psychologist Assessment



11.2.12 CF Social Worker Assessment



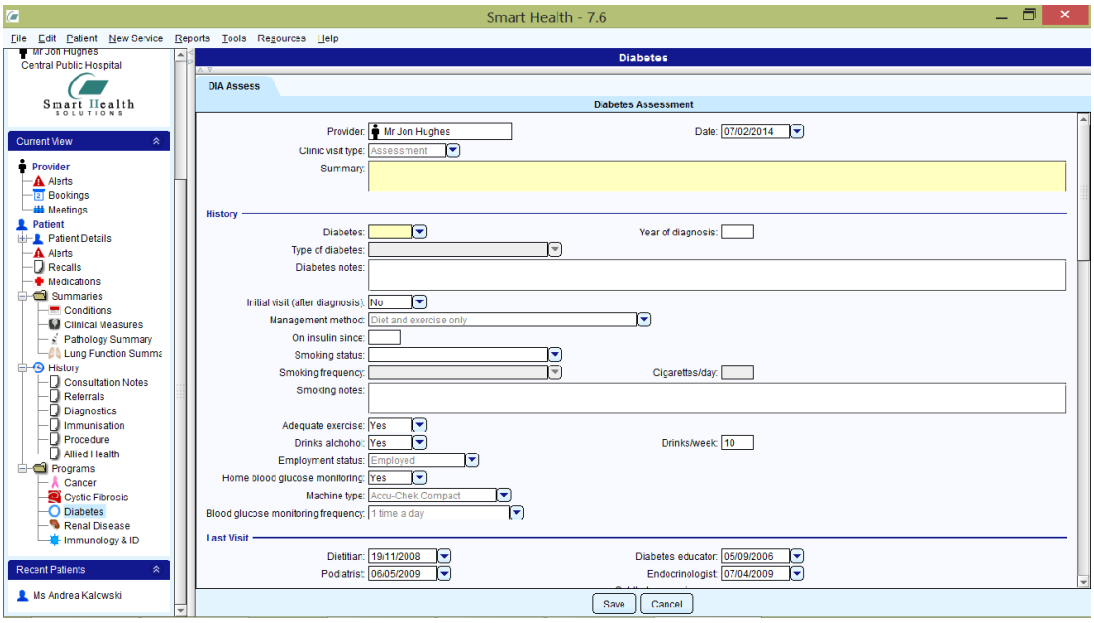


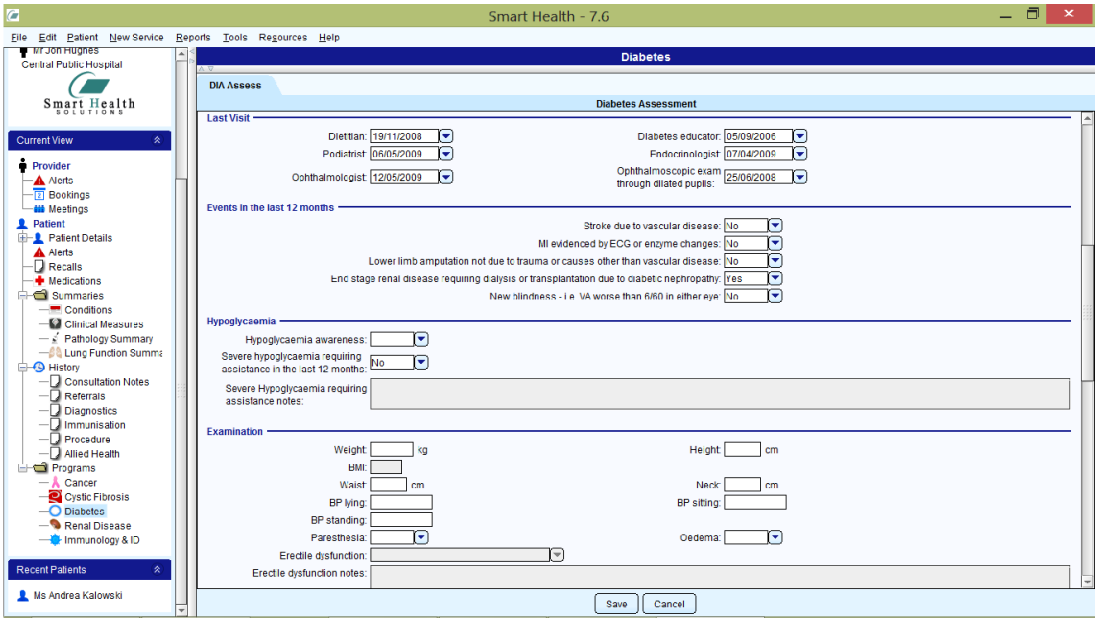
11.3 Diabetes

The Diabetes program includes detailed data capture forms to support Diabetes healthcare management.

11.3.1 Clinical Assessment

The Clinical Assessment, also referred to as a Complications Review, capture key assessment data for Diabetes patients.




Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
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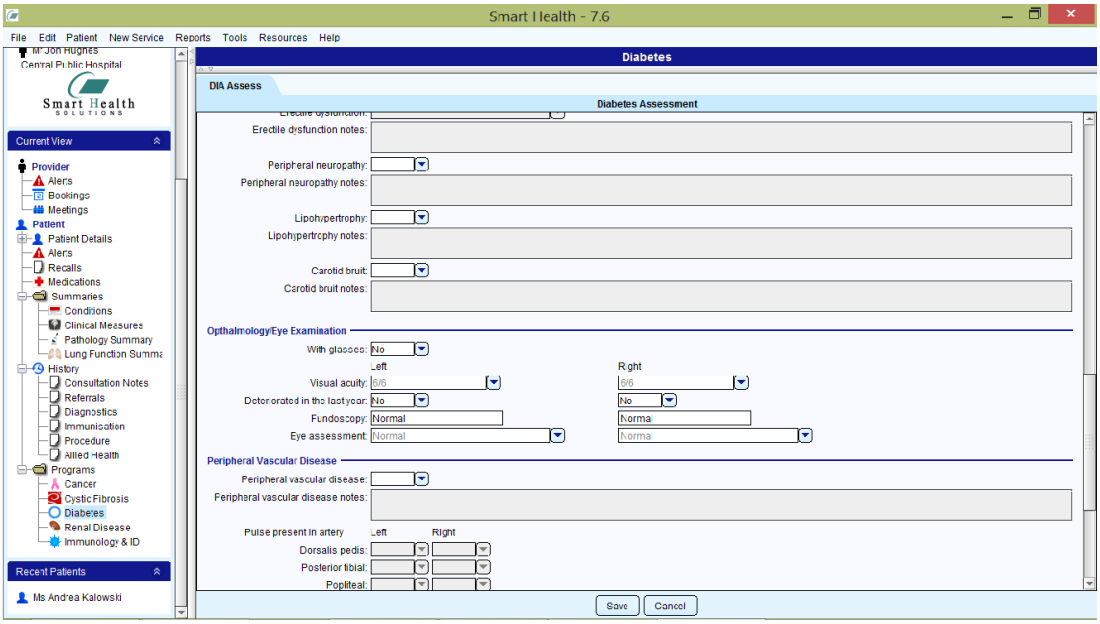
Programs
Cancer
Cystic Fibrosis
Diabetes
Renal Disease
Immunology & ID
Recent Patients
Ms Andrea Kalowski
Diabetes
DIA Assess
Diabetes Assessment
Last Visit
Dietitian: 19/11/2008
Podiatrist: 06/05/2009
Ophthalmolgist: 12/05/2009
Diabetes educator: 05/09/2006
Endocrinologist: 07/04/2005
Ophthalmoscopic exam through dilated pupils: 25/06/2008
Events in the last 12 months
Stroke due to vascular disease: No
MI evidenced by ECG or enzyme changes: No
Lower limb amputation not due to trauma or causes other than vascular disease: No
End stage renal disease requiring dialysis or transplantation due to diabetic nephropathy: Yes
New blindness - i.e. VA worse than 6/60 in either eye: No
Hypoglycaemia
Hypoglycaemia awareness:
Severe hypoglycaemia requiring assistance in the last 12 months: No
Severe Hypoglycaemia requiring assistance notes:
Examination
Weight: kg
Height: cm
BMI:
Waist: cm
Neck: cm
BP lying:
BP sitting:
BP standing:
Paresthesia:
Oedema:
Erectile dysfunction:
Erectile dysfunction notes:
Save
Cancel


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Central Public Hospital
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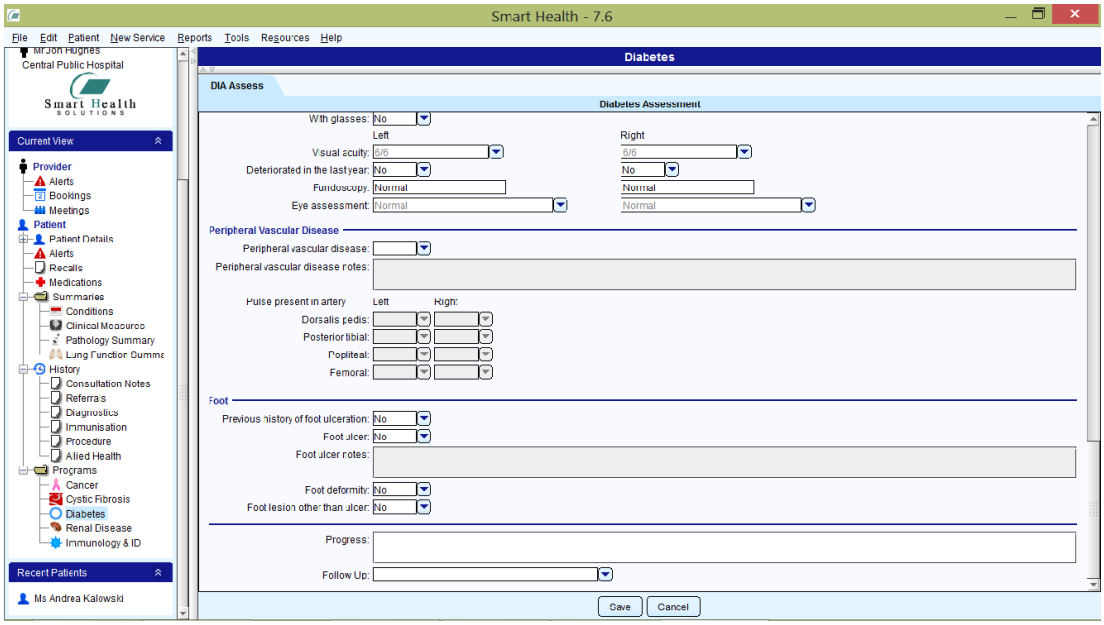
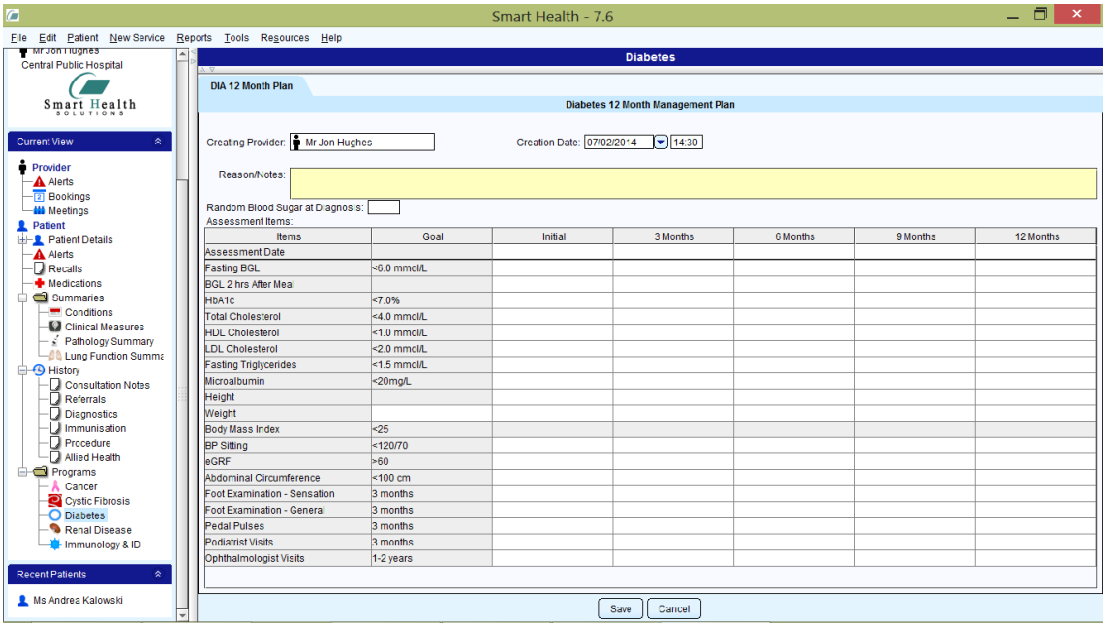
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Programs
Cancer
Cystic Fibrosis
Diabetes
Renal Disease
Immunology & ID
Recent Patients
Ms Andrea Kalowski
Diabetes
DIA Assess
Diabetes Assessment
Erectile dysfunction notes:
Peripheral neuropathy:
Peripheral neuropathy notes:
Lipohypertrophy:
Lipohypertrophy notes:
Carotid bruit:
Carotid bruit notes:
Opthalmology/Eye Examination
With glasses: No
Left
Right
Visual acuity: 6/6 6/6
Deteriorated in the last year: No No
Fundoscopy: Normal Normal
Eye assessment: Normal Normal
Peripheral Vascular Disease
Peripheral vascular disease:
Peripheral vascular disease notes:
Pulse present in artery
Left
Right
Dorsalis pedis:
Posterior tibial:
Popliteal:
Save
Cancel



11.3.2 12-Month Management Plan

The 12-Month Management Plan is an enhanced Primary Care tool that provides quarterly assessment of key Diabetes indicators.



11.3.3 Blood Glucose Monitor

The Blood Glucose Monitor is a patient blood glucose recording tool that can be used by the practice to record daily blood sugar levels. It is also being trialled by patients for home use.

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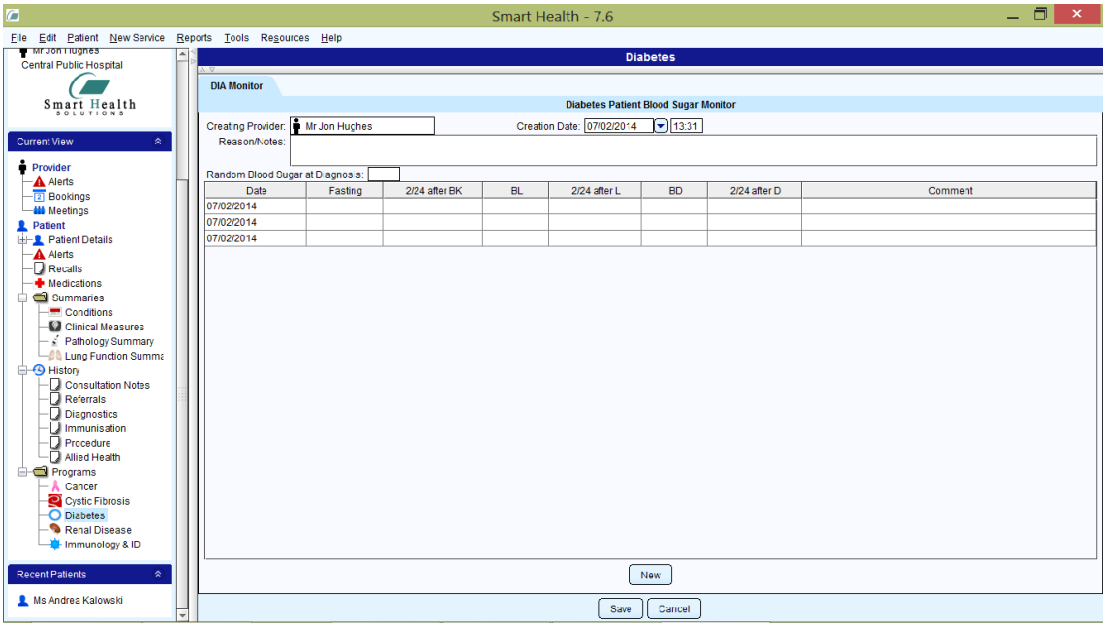
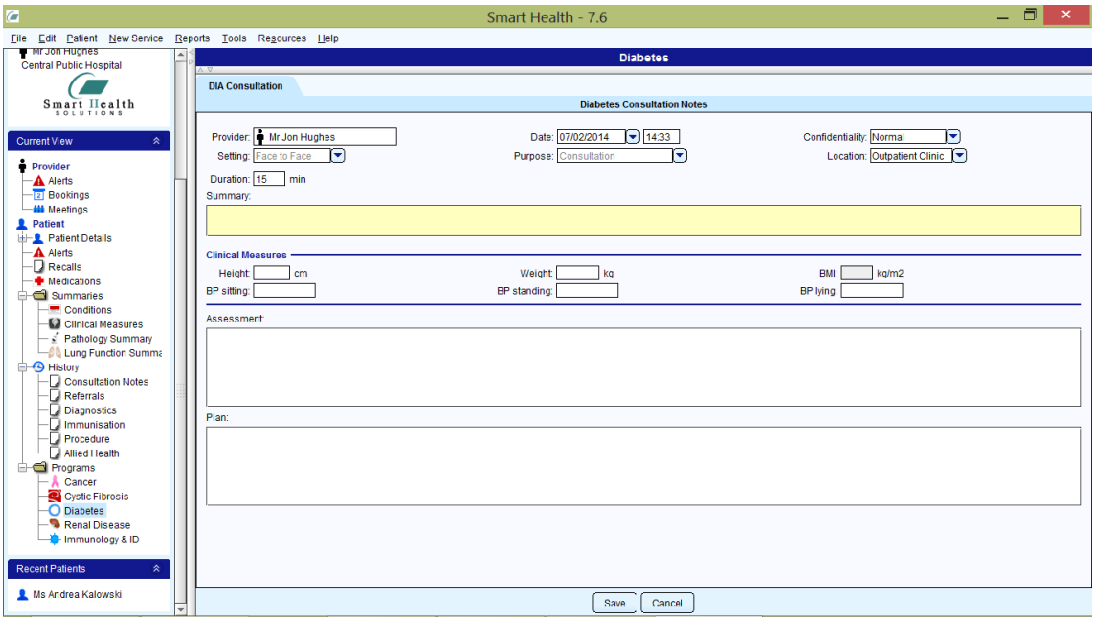
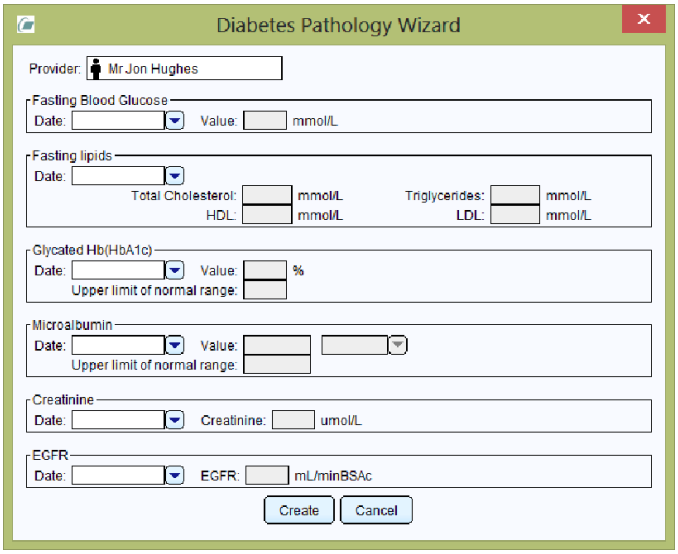


11.3.4 Diabetes Consultation Note



11.3.5 Diabetes Pathology Wizard

The Diabetes Pathology Wizard allows users to manually enter key pathology results into Smart Health.



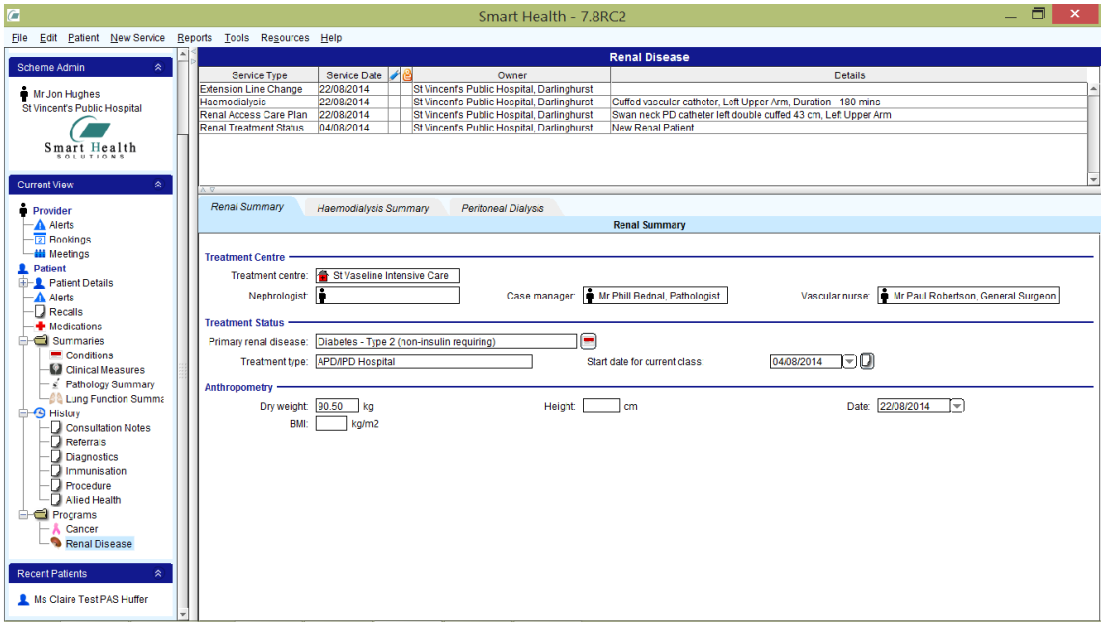
11.4 Renal Disease

The Renal Disease program includes a broad variety of forms for managing patients with chronic kidney disease:

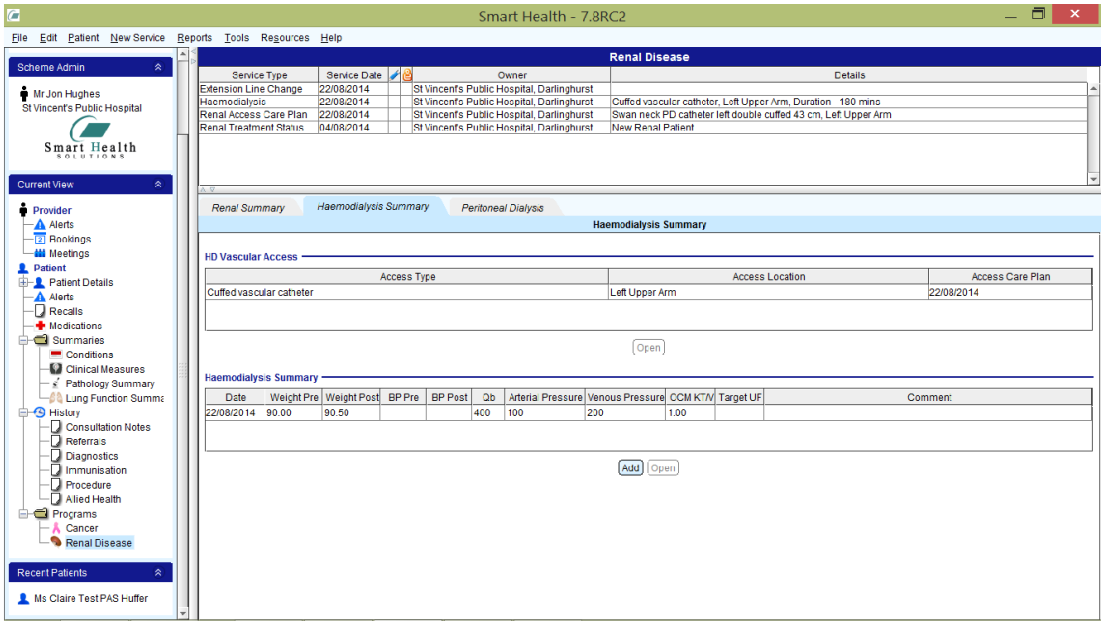
11.4.1 Renal Summary

The renal summary presents a read-only view of key renal clinical indicators, with separate summary pages for a renal summary, haemodialysis, peritoneal dialysis and transplantation.

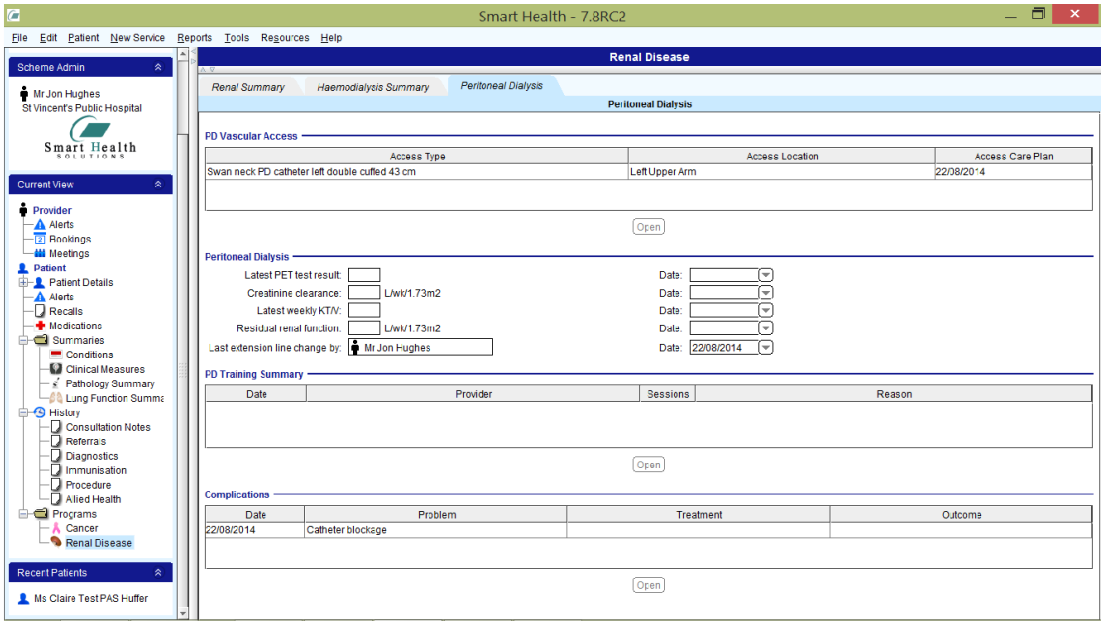
Renal Summary:



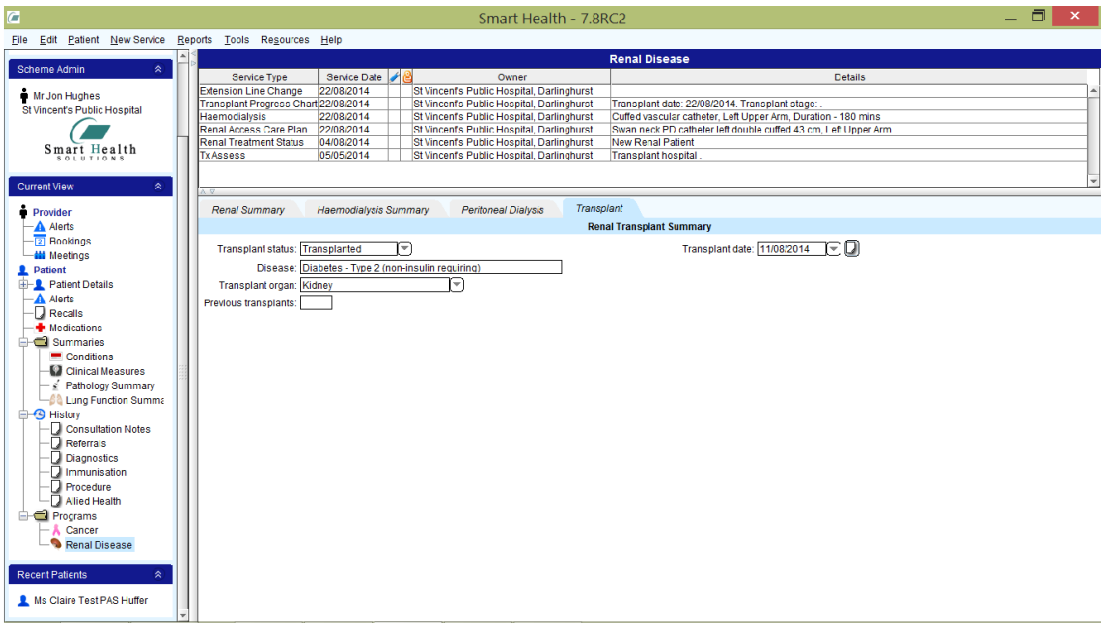
Haemodialysis Summary:


Smart Health - 7.8RC2
File Edit Patient New Service Reports Tools Resources Help
Renal Disease
Service Type | Service Date | Owner | Details
Extension Line Change | 22/08/2014 | St Vincent's Public Hospital, Darlinghurst
Haemodialysis | 22/08/2014 | St Vincent's Public Hospital, Darlinghurst | Cuffed vascular catheter, Left Upper Arm, Duration 180 mins
Renal Access Care Plan | 22/08/2014 | St Vincent's Public Hospital, Darlinghurst | Swan neck PD catheter left double cuffed 43 cm, Left Upper Arm
Renal Treatment Status | 04/08/2014 | St Vincent's Public Hospital, Darlinghurst | New Renal Patient
Renal Summary | Haemodialysis Summary | Peritoneal Dialysis
Haemodialysis Summary
HD Vascular Access
Access Type | Access Location | Access Care Plan
Cuffed vascular catheter | Left Upper Arm | 22/08/2014
Open
Haemodialysis Summary
Date | Weight Pre | Weight Post | BP Pre | BP Post | Qb | Arteria Pressure | Venous Pressure | CCM KT/V | Target UF | Comment
22/08/2014 | 90.00 | 90.50 | 400 | 100 | 200 | 1.00
Add | Open
Scheme Admin
Mr Jon Hughes
St Vincent's Public Hospital
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summa
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Allied Health
Programs
Cancer
Renal Disease
Recent Patients
Ms Claire Test PAS Huffer

Peritoneal Dialysis Summary:



Transplant Summary:



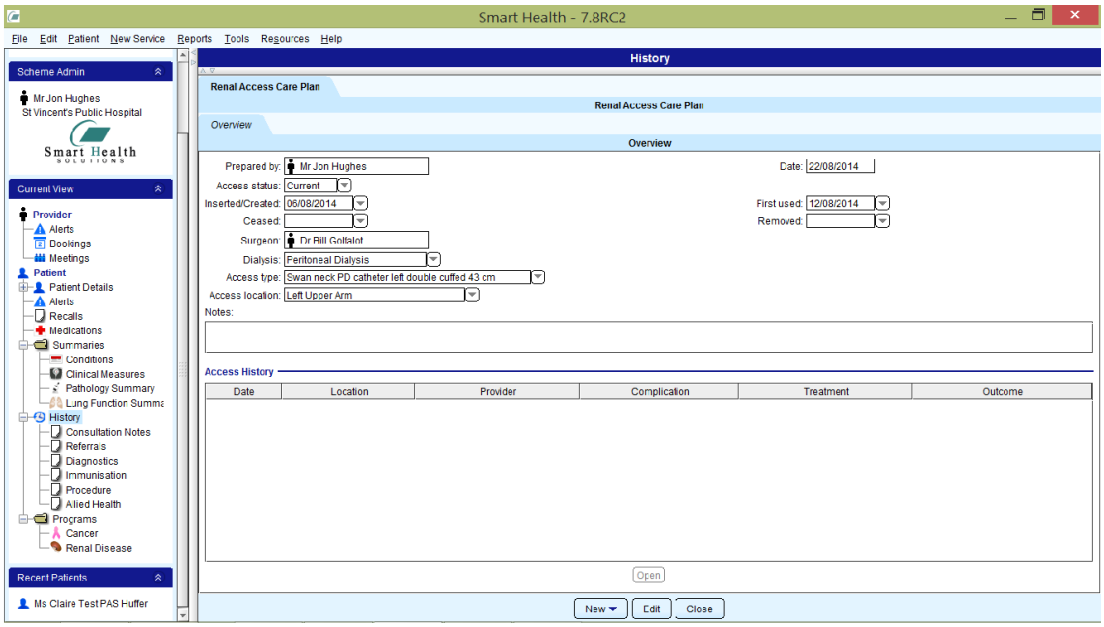
11.4.2 Care Plans

Select New Service/Renal Disease/Care Plans to create renal care plans:

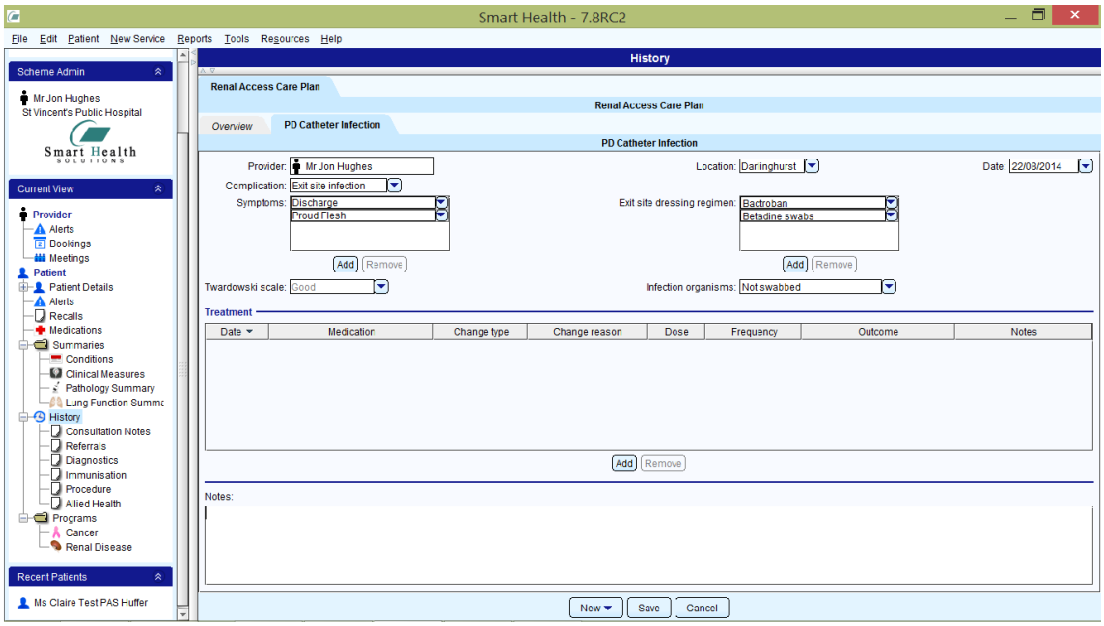
Care Plans are used to record treatment planning details for kidney disease management. For example, the Haemodialysis Prescription records details for Haemodialysis settings.

11.4.2.1 Access Care Plan

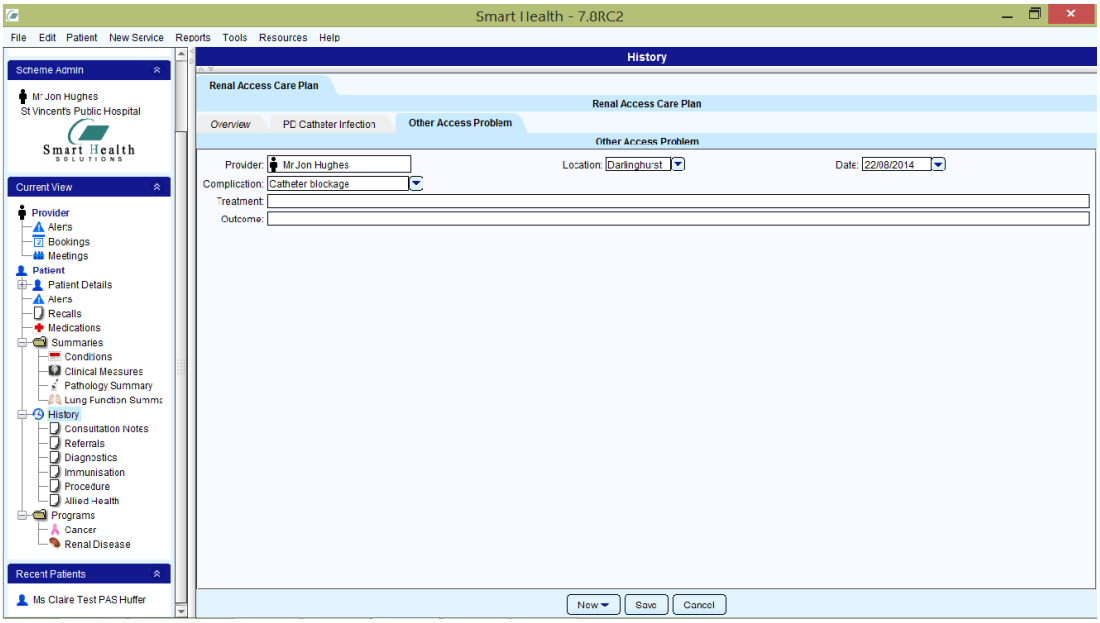
Access Care plans record details for each of a patient's accesses, including the recording of PD Catheter Infections and other access problems:



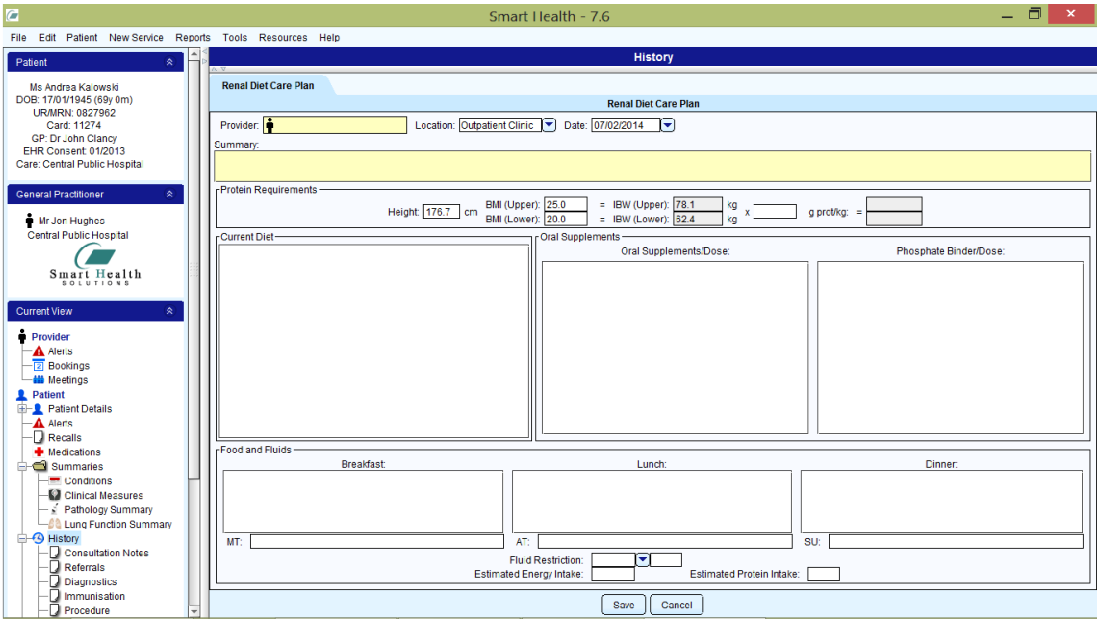
11.4.2.1.1 PD Catheter Infection



11.4.2.1.2 Other Access Problem

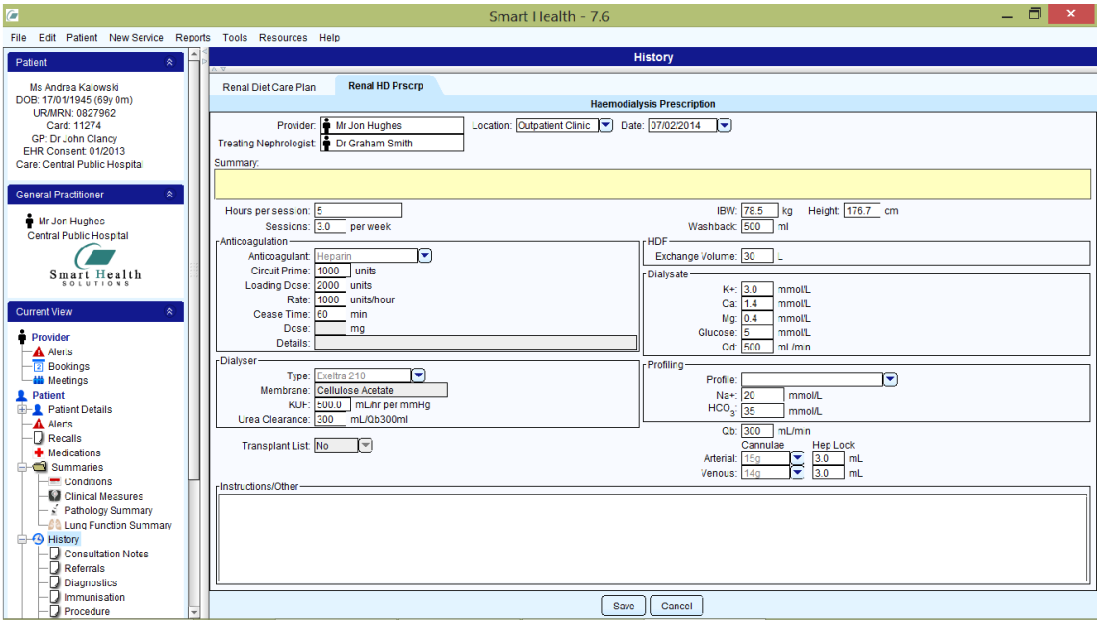


11.4.2.2 Dietitian Care Plan



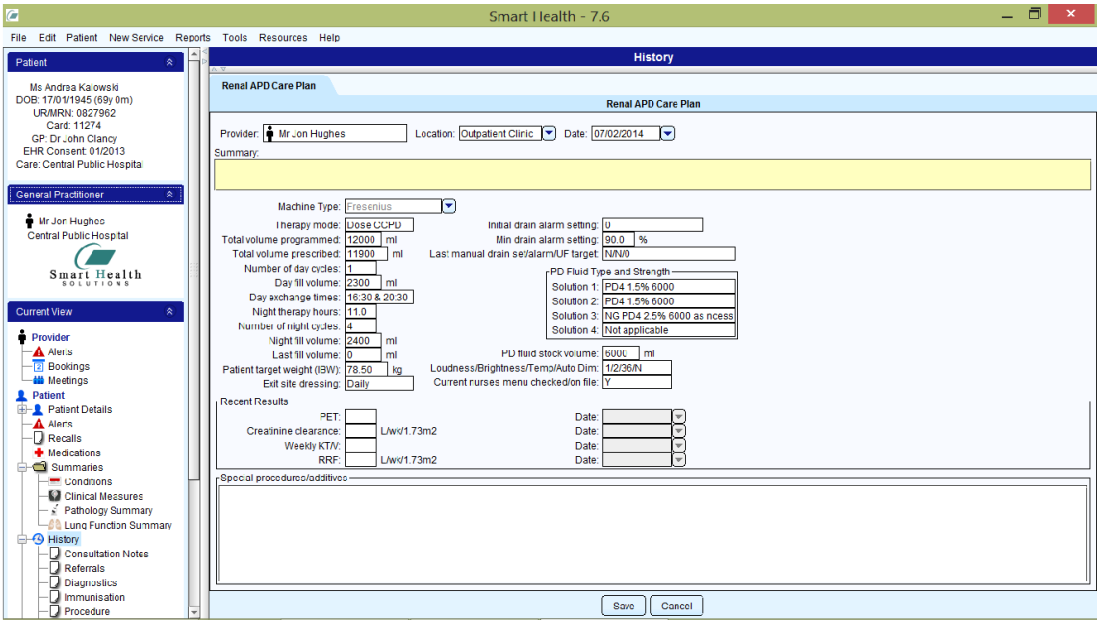
11.4.2.3 Haemodialysis Prescription

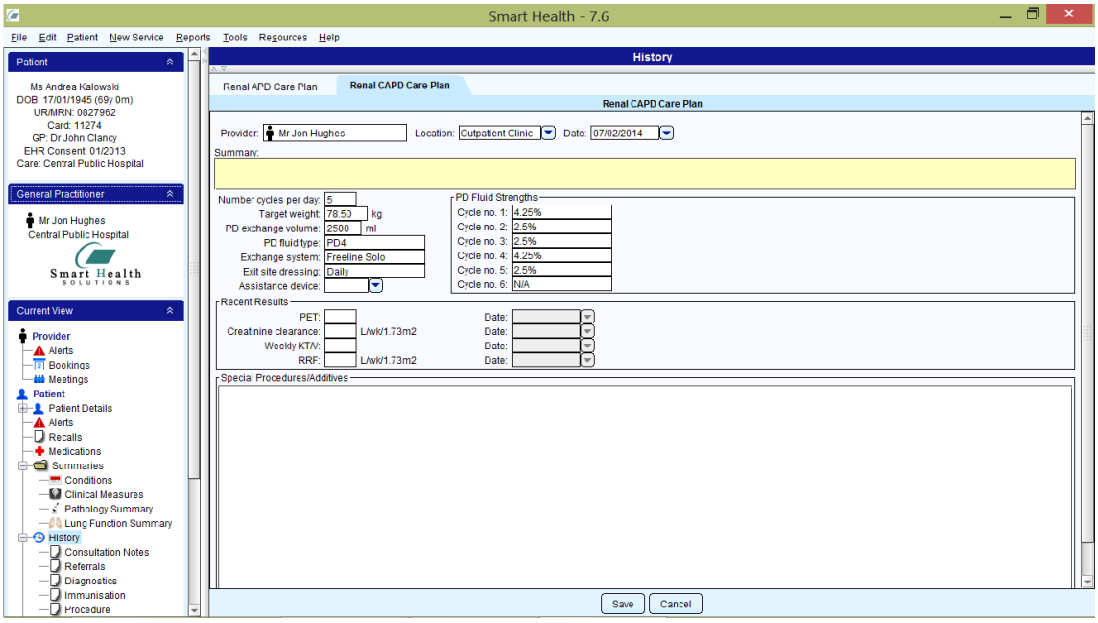
A new haemodialysis prescription is automatically populated from the most recent haemodialysis prescription. Haemodialysis prescriptions are not editable once they have been saved.



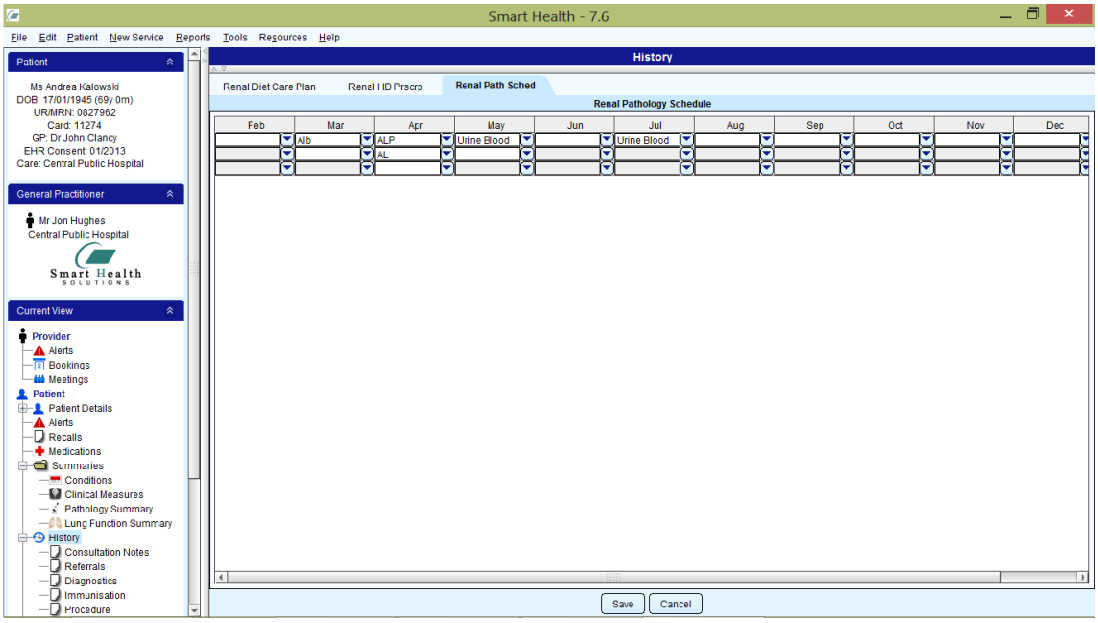
11.4.2.4 PD Prescription

Peritoneal dialysis prescriptions record ambulatory peritoneal dialysis and continuous ambulatory peritoneal dialysis care plan information. A new peritoneal dialysis prescription is automatically populated from the most recent peritoneal dialysis prescription. Peritoneal dialysis prescriptions are not editable once they have been saved.

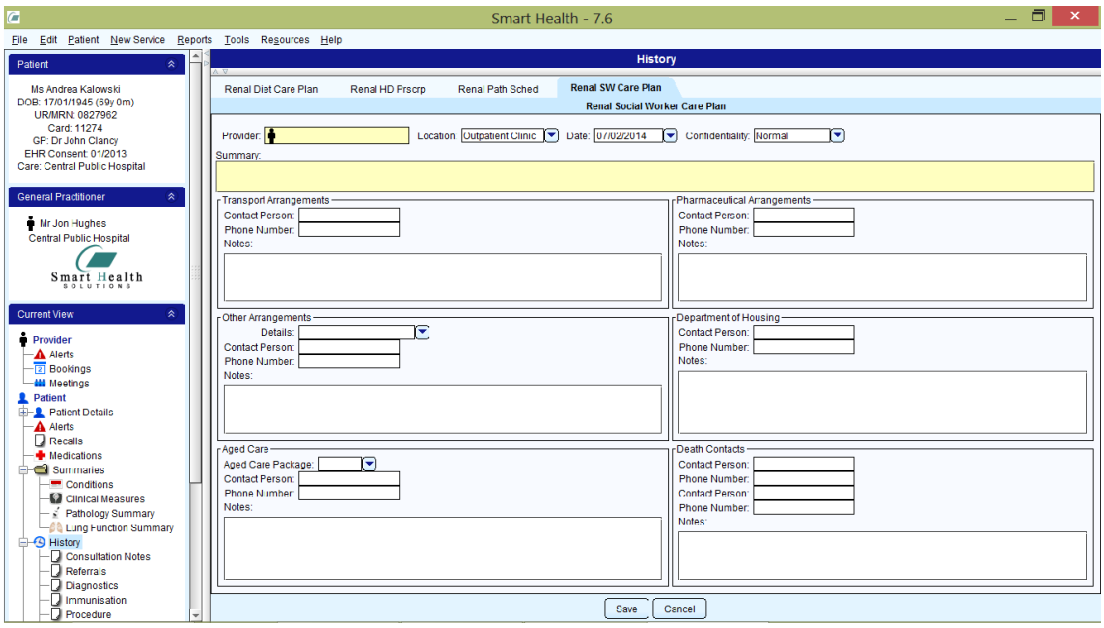




11.4.2.5 Pathology Schedule

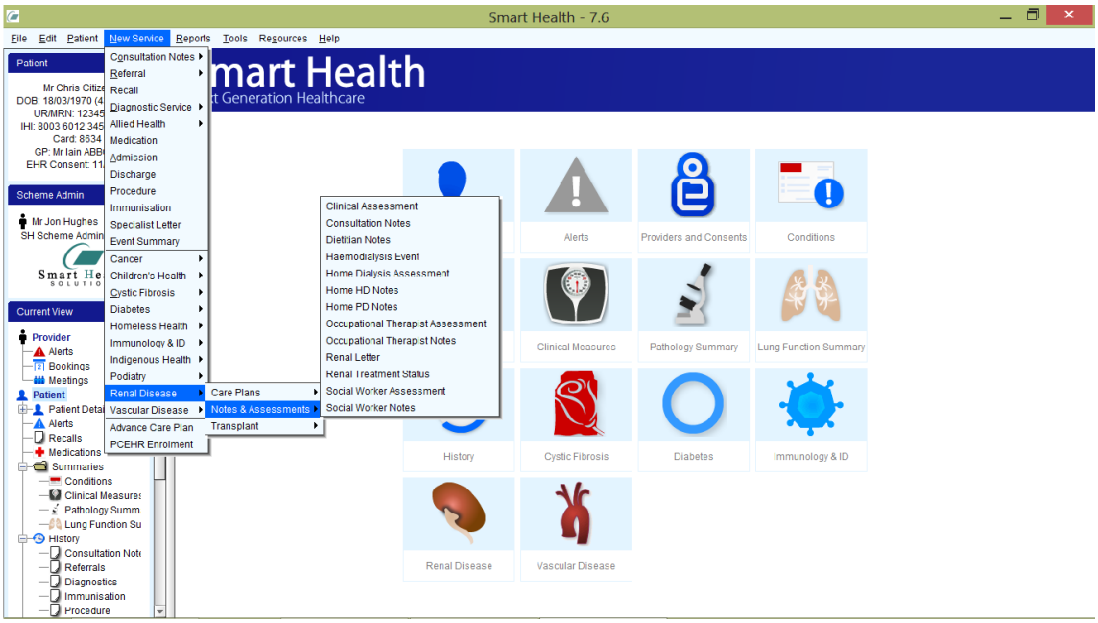


11.4.2.6 Social Worker Care Plan

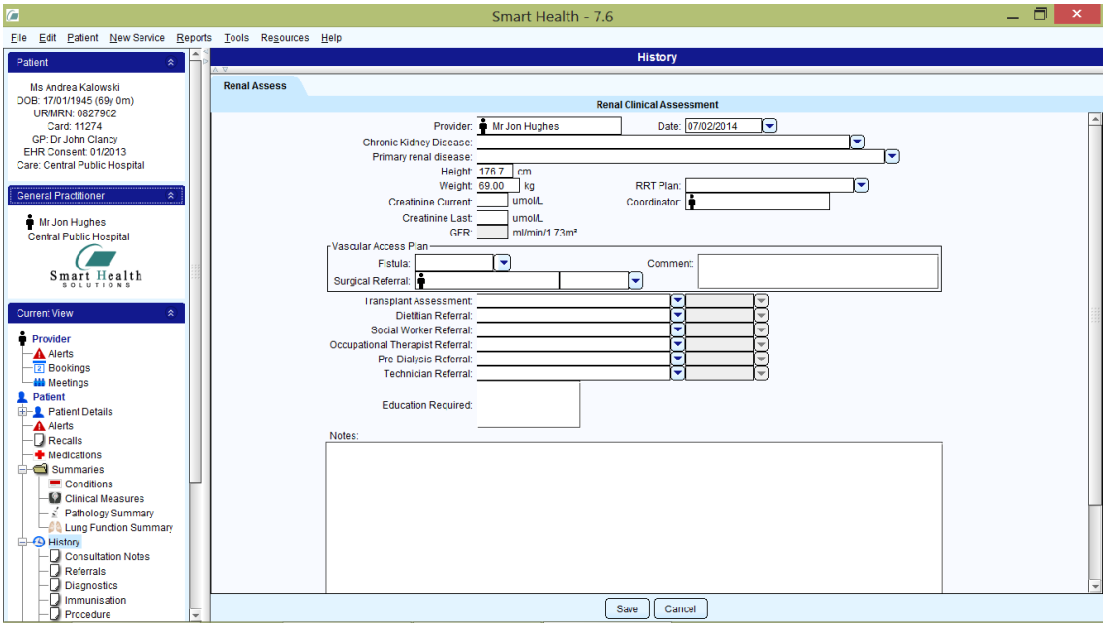


11.4.3 Notes and Assessments

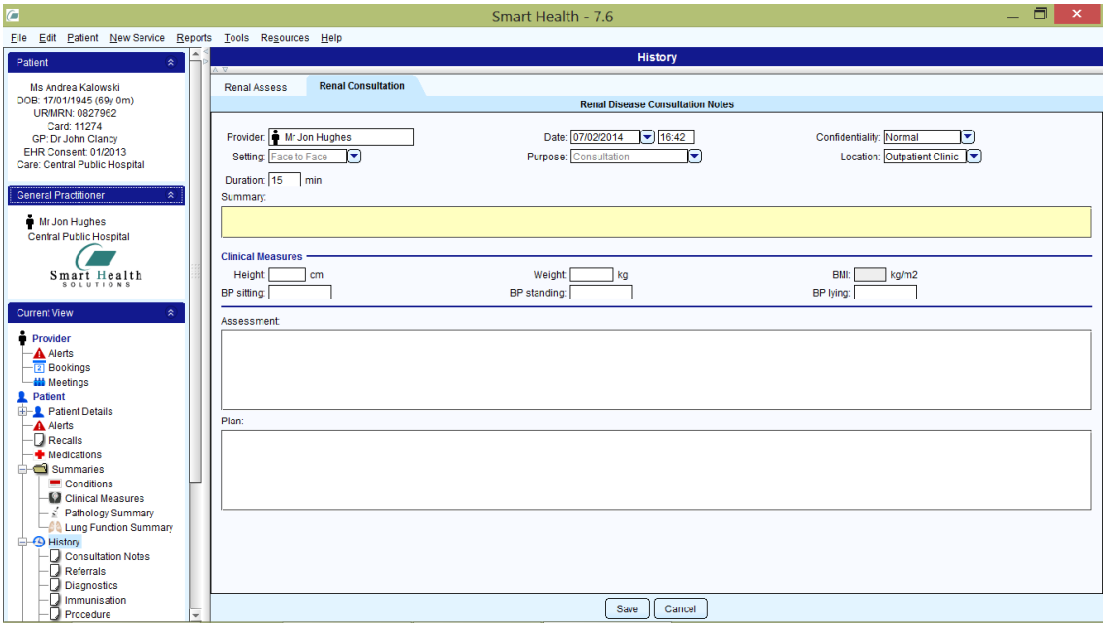
Select New Service/Renal Disease/Notes & Assessments to create renal patient notes:



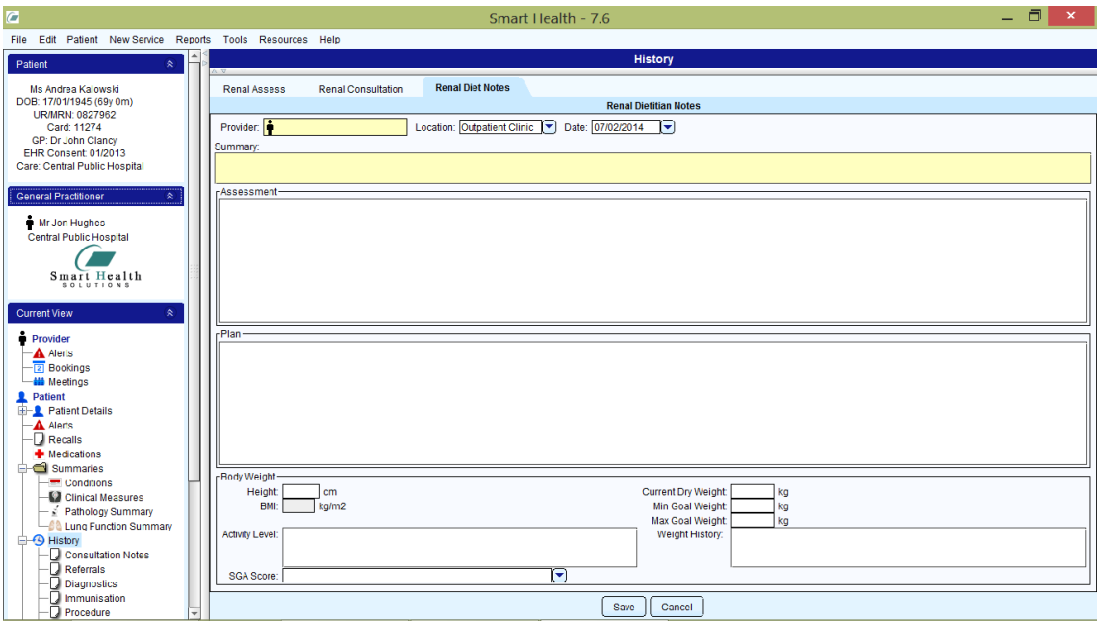
11.4.3.1 Clinical Assessment



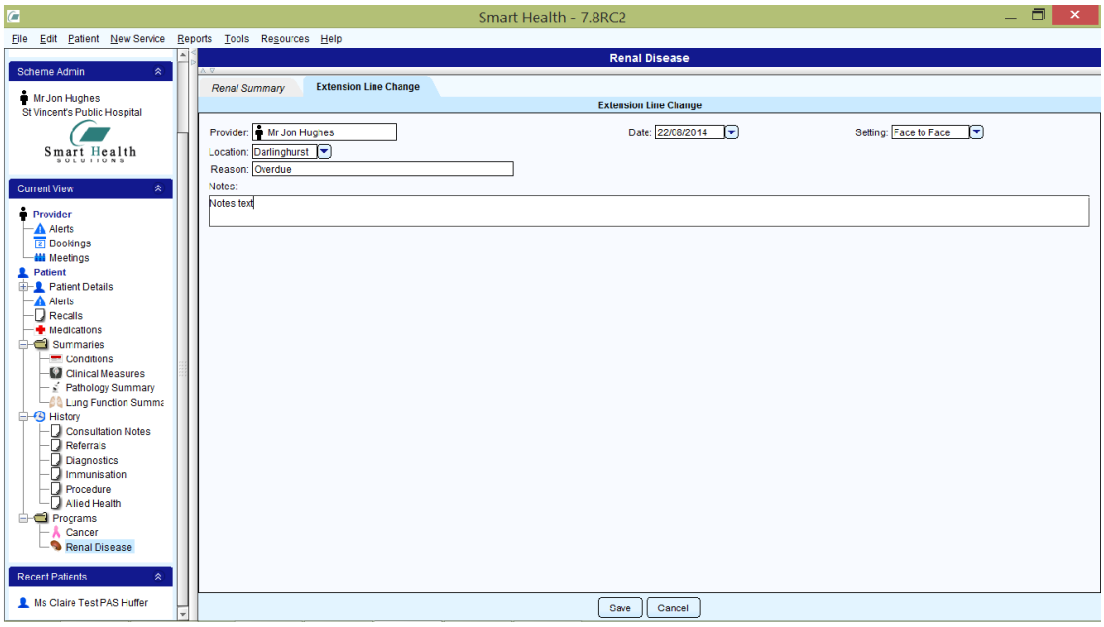
11.4.3.2 Consultation Notes



11.4.3.3 Dietitian Notes



11.4.3.4 Extension Line Change



11.4.3.5 Haemodialysis Event

Haemodialysis results are presented in the Renal Summary view if the patient is on haemodialysis.

New haemodialysis records can be created from the New Service menu or from the Haemodialysis Summary.

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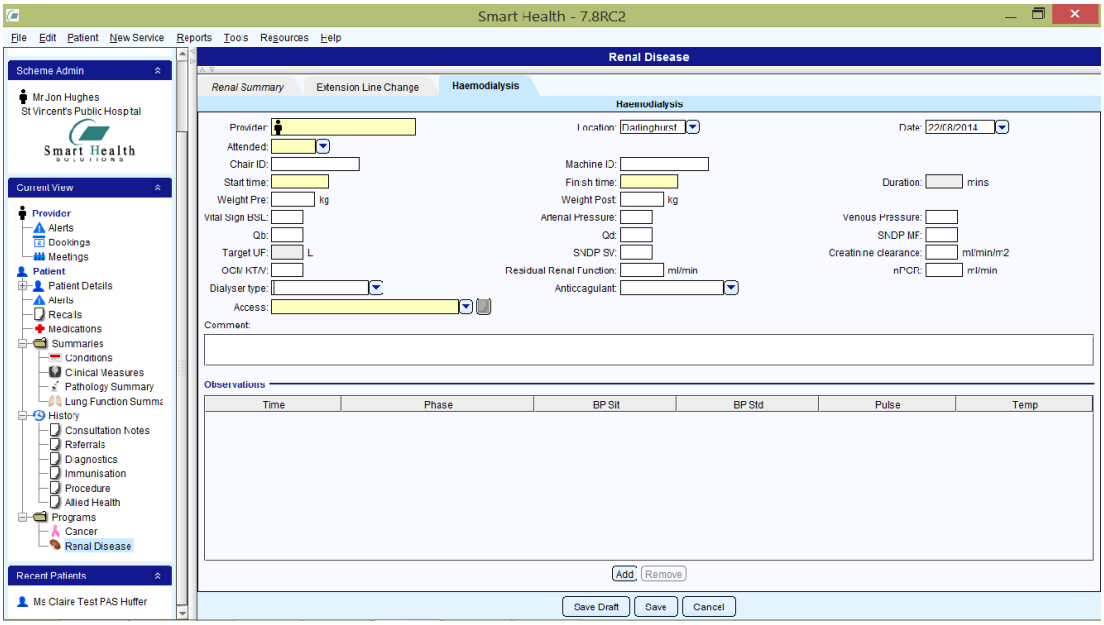
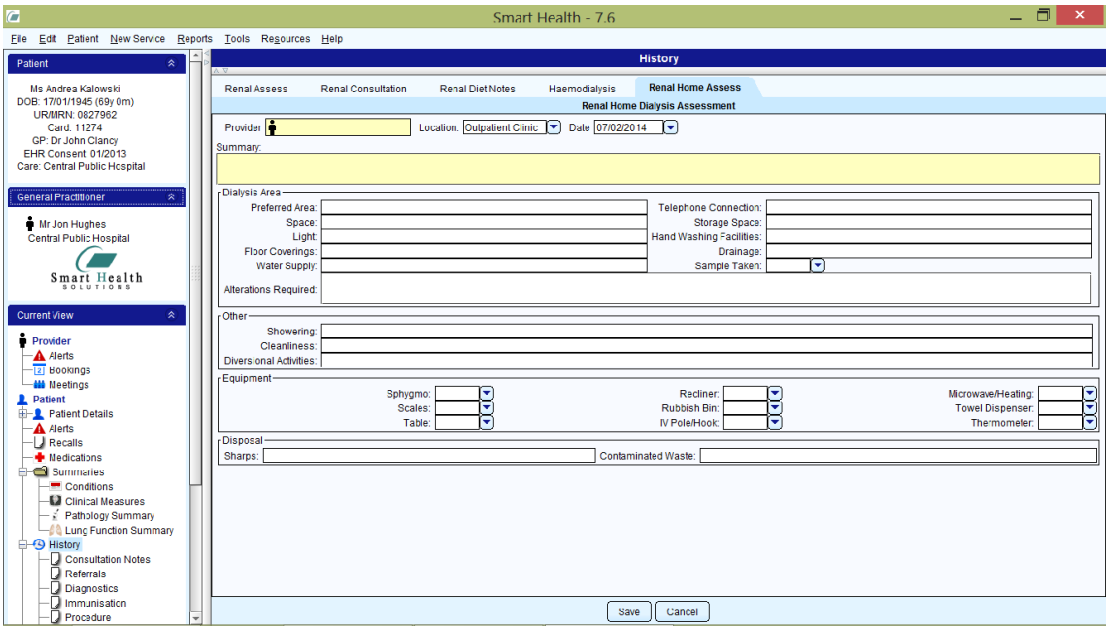
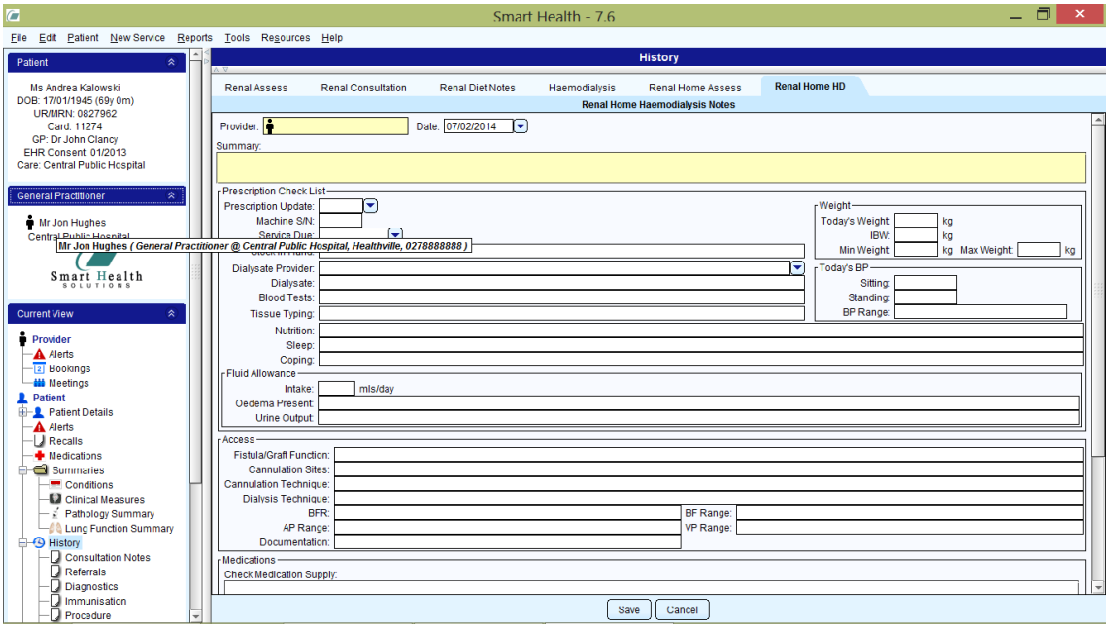


11.4.3.6 Home Dialysis Assessment

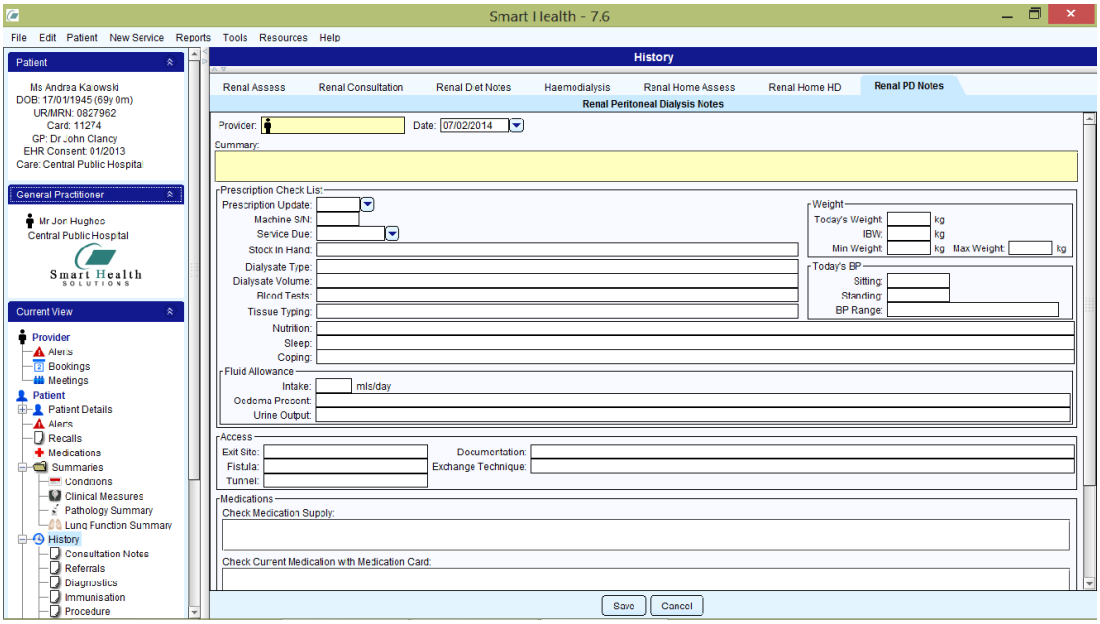


11.4.3.7 Home HD Notes

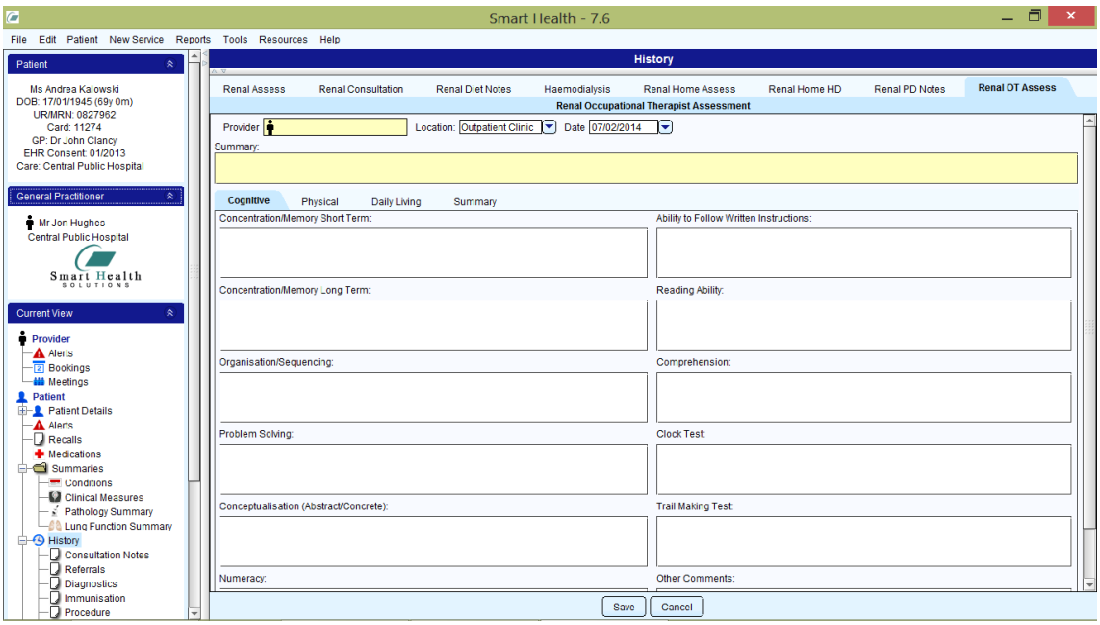


11.4.3.8 PD Notes

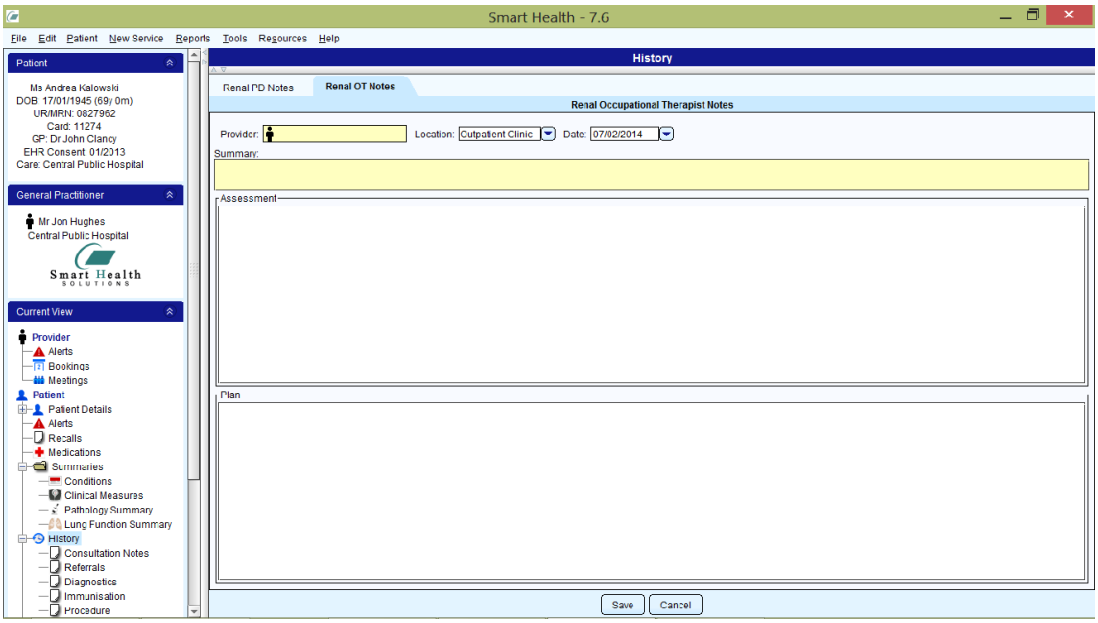
This record is being redeveloped. The current form is:



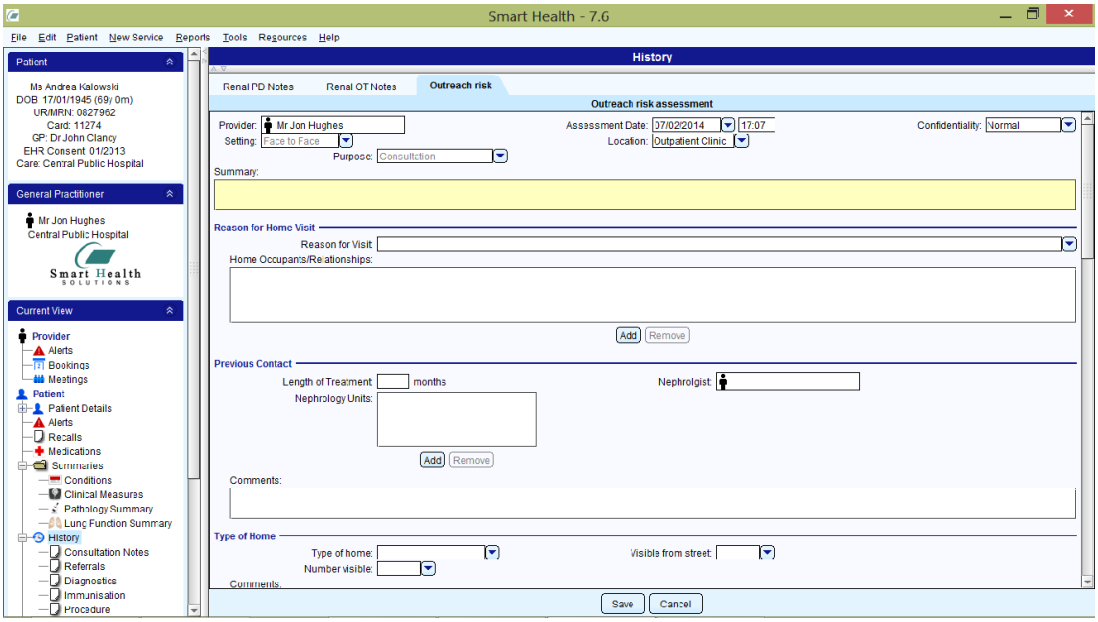
11.4.3.9 Occupational Therapist Assessment

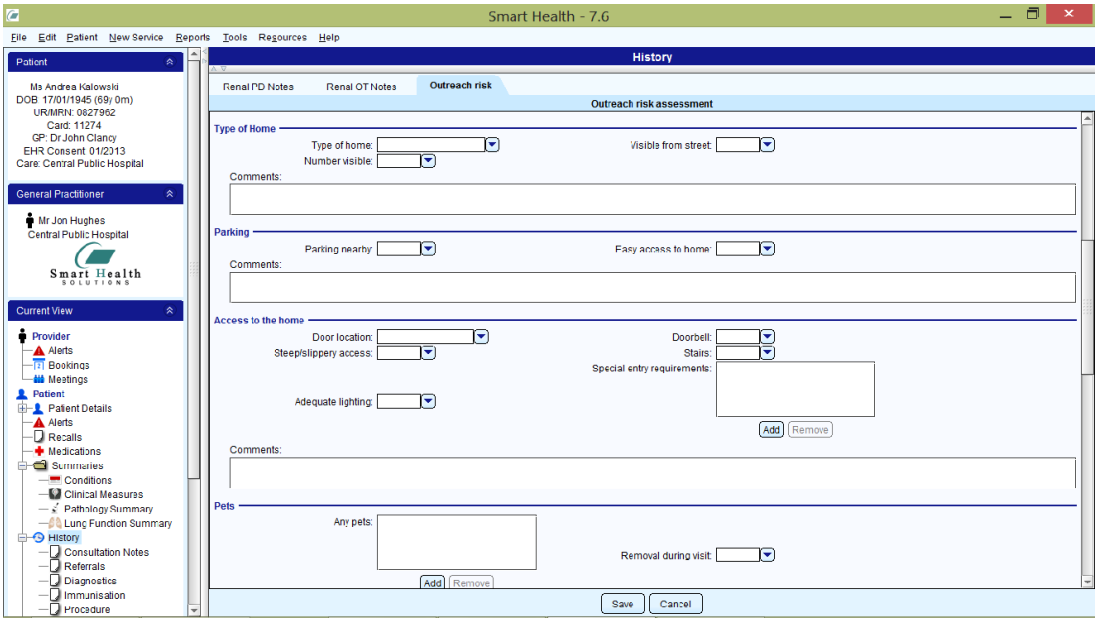


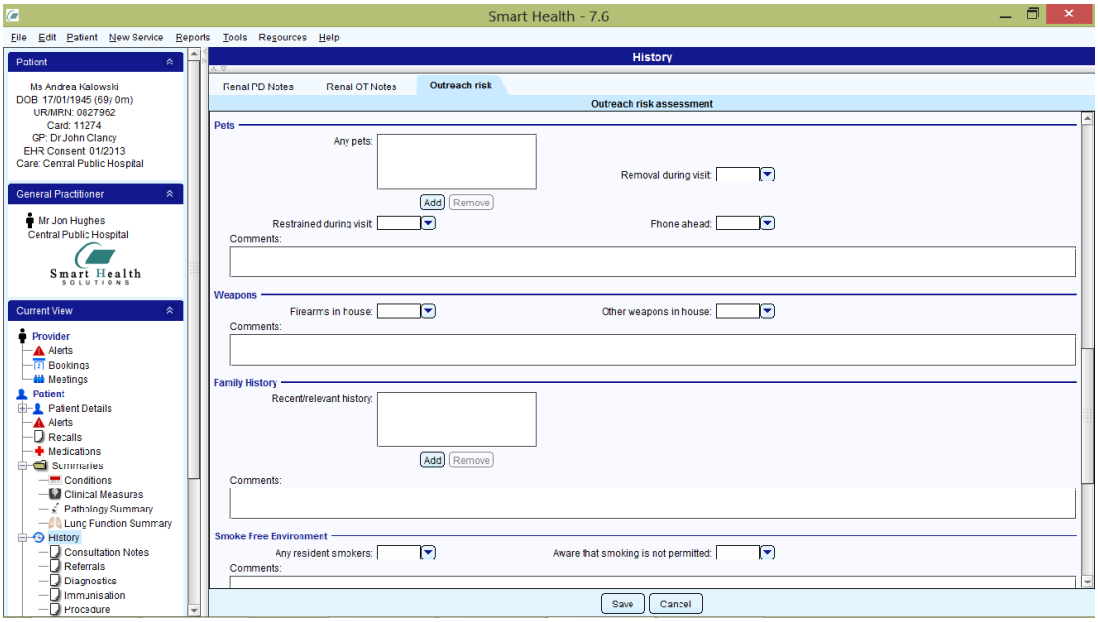
11.4.3.10 Occupational Therapist Notes



11.4.3.11 Outreach Risk Assessment






Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
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Meetings
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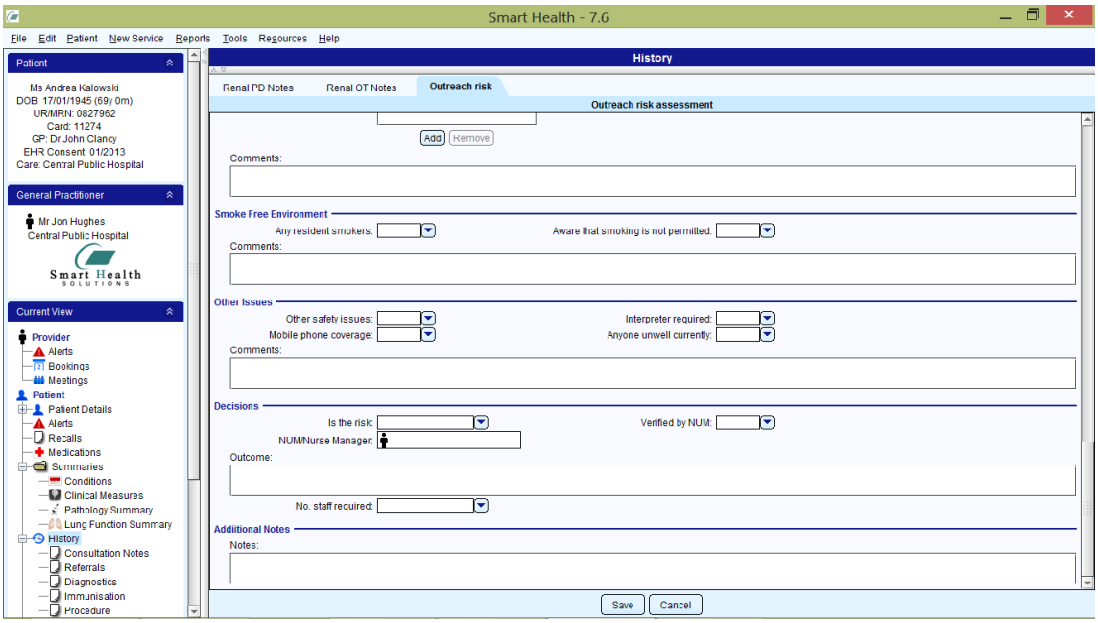
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Renal PD Notes
Renal OT Notes
Outreach risk
Outreach risk assessment
Pets
Any pets:
Add
Remove
Removal during visit:
Restrained during visit:
Phone ahead:
Comments:
Weapons
Firearms in house:
Other weapons in house:
Comments:
Family History
Recent/relevant history:
Add
Remove
Comments:
Smoke Free Environment
Any resident smokers:
Aware that smoking is not permitted:
Comments:
Save
Cancel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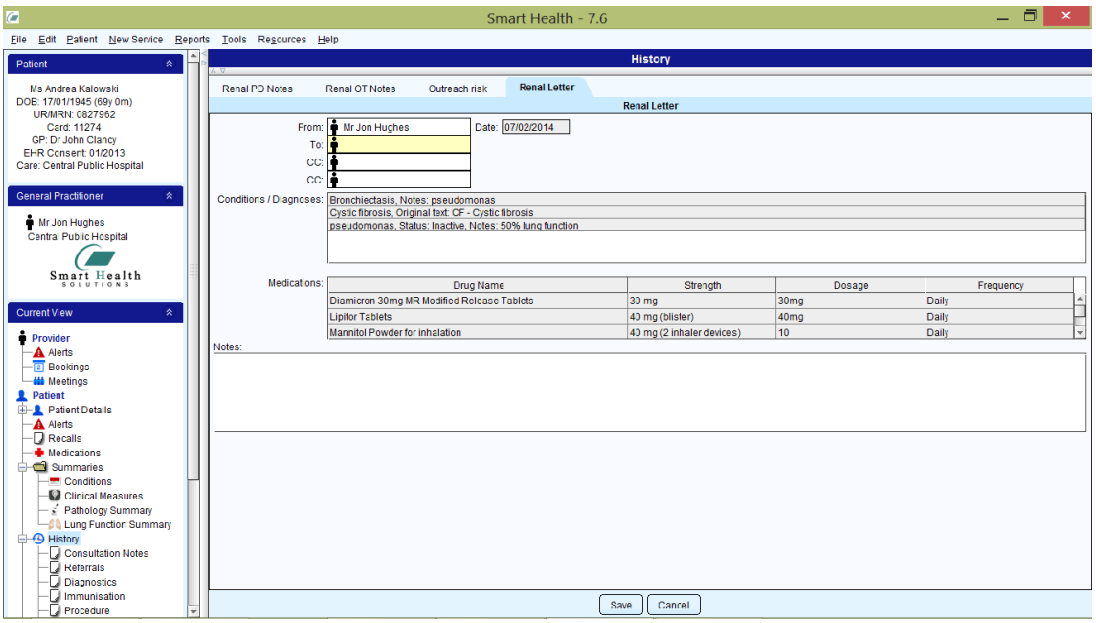
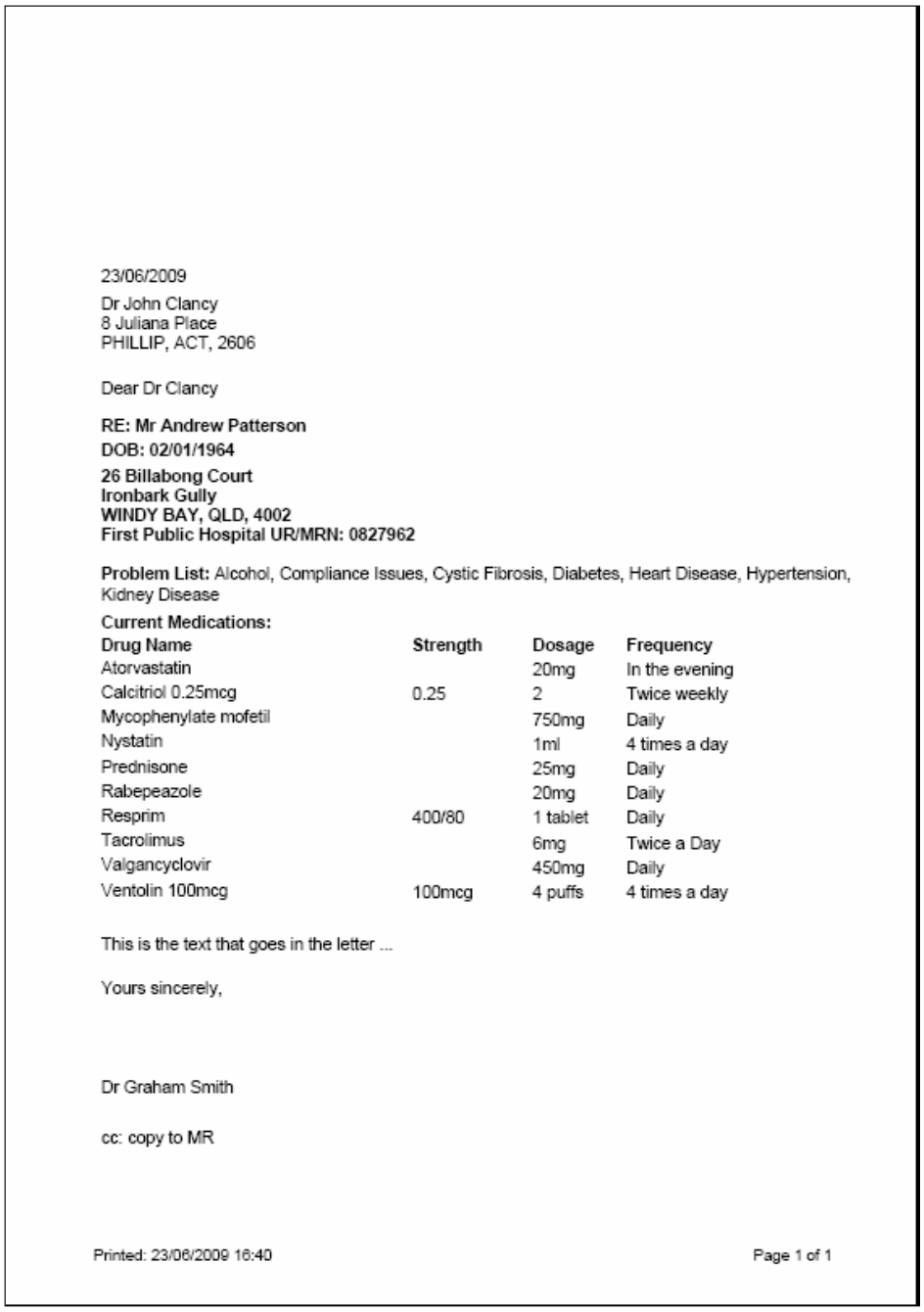
Lung Function Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Renal PD Notes
Renal OT Notes
Outreach risk
Outreach risk assessment
Add
Remove
Comments:
Smoke Free Environment
Any resident smokers:
Aware that smoking is not permitted:
Comments:
Other Issues
Other safety issues:
Interpreter required:
Mobile phone coverage:
Anyone unwell currently:
Comments:
Decisions
Is the risk:
Verified by NUM:
NUM/Nurse Manager:
Outcome:
No. staff required:
Additional Notes
Notes:
Save
Cancel

11.4.3.12 Renal Letter



When the Letter is saved, it can be printed as a “pdf” file and emailed to referring providers, printed and posted to referring providers (or handed to the patient) and also viewed on-line.



23/06/2009

Dr John Clancy
8 Juliana Place
PHILLIP, ACT, 2606

Dear Dr Clancy

RE: Mr Andrew Patterson
DOB: 02/01/1964
26 Billabong Court
Ironbark Gully
WINDY BAY, QLD, 4002
First Public Hospital UR/MRN: 0827962

Problem List: Alcohol, Compliance Issues, Cystic Fibrosis, Diabetes, Heart Disease, Hypertension, Kidney Disease

Current Medications:

Drug Name	Strength	Dosage	Frequency
Atorvastatin		20mg	In the evening
Calcitriol 0.25mcg	0.25	2	Twice weekly
Mycophenylate mofetil		750mg	Daily
Nystatin		1ml	4 times a day
Prednisone		25mg	Daily
Rabepeazole		20mg	Daily
Resprim	400/80	1 tablet	Daily
Tacrolimus		6mg	Twice a Day
Valgancyclovir		450mg	Daily
Ventolin 100mcg	100mcg	4 puffs	4 times a day

This is the text that goes in the letter ...

Yours sincerely,

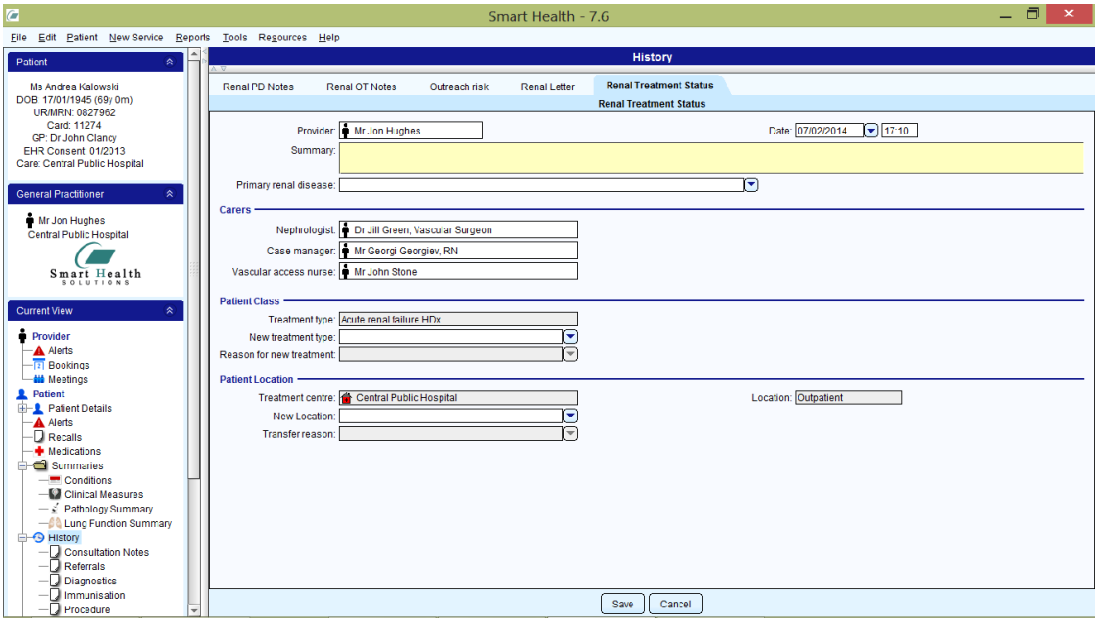
Dr Graham Smith

cc: copy to MR

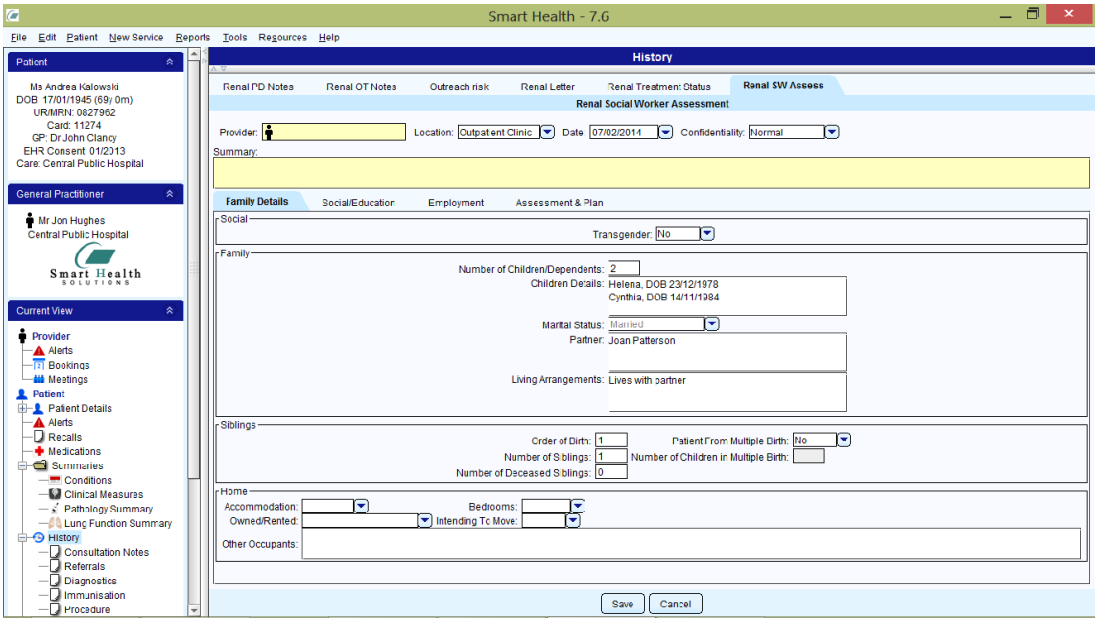
Printed: 23/06/2009 16:40 Page 1 of 1

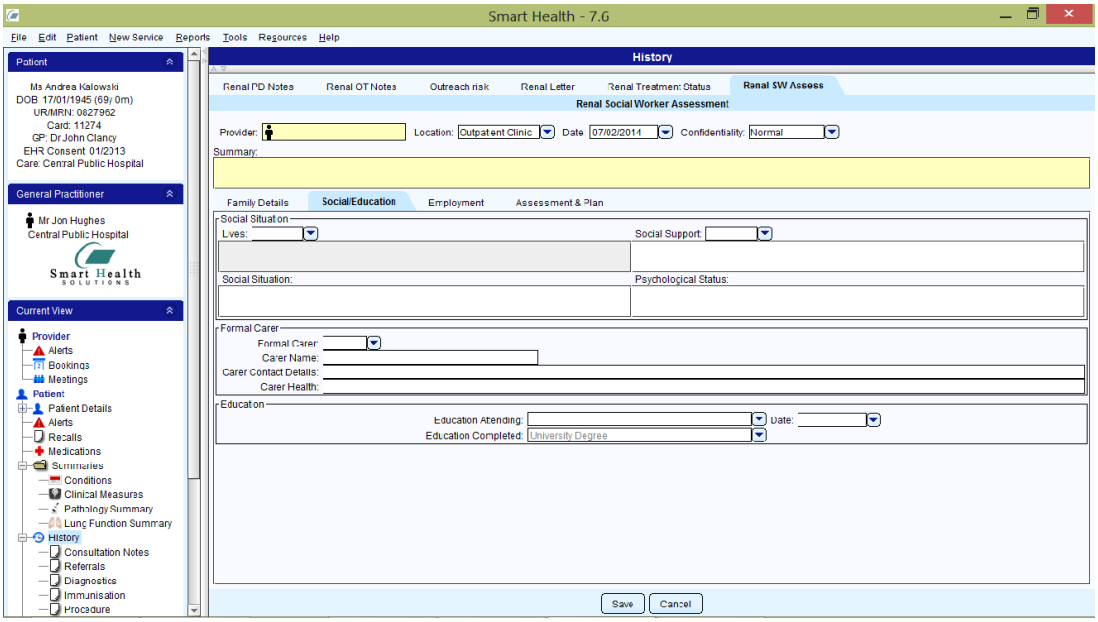
11.4.3.13 Renal Treatment Status

Renal Treatment Status captures changes to renal treatment modality, treatment centre and other parameters in an ANZDATA compliant format.



11.4.3.14 Social Worker Assessment

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Patient
Ms Andrea Kalowski
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Lung Function Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Renal PD Notes
Renal OT Notes
Outreach risk
Renal Letter
Renal Treatment Status
Renal SW Assess
Renal Social Worker Assessment
Provider:
Location: Outpatient Clinic
Date: 07/02/2014
Confidentiality: Normal
Summary:
Family Details
Social/Education
Employment
Assessment & Plan
Social Situation
Lives:
Social Support:
Social Situation:
Psychological Status:
Formal Carer
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Carer Name:
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Carer Health:
Education
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Date:
Education Completed: University Degree
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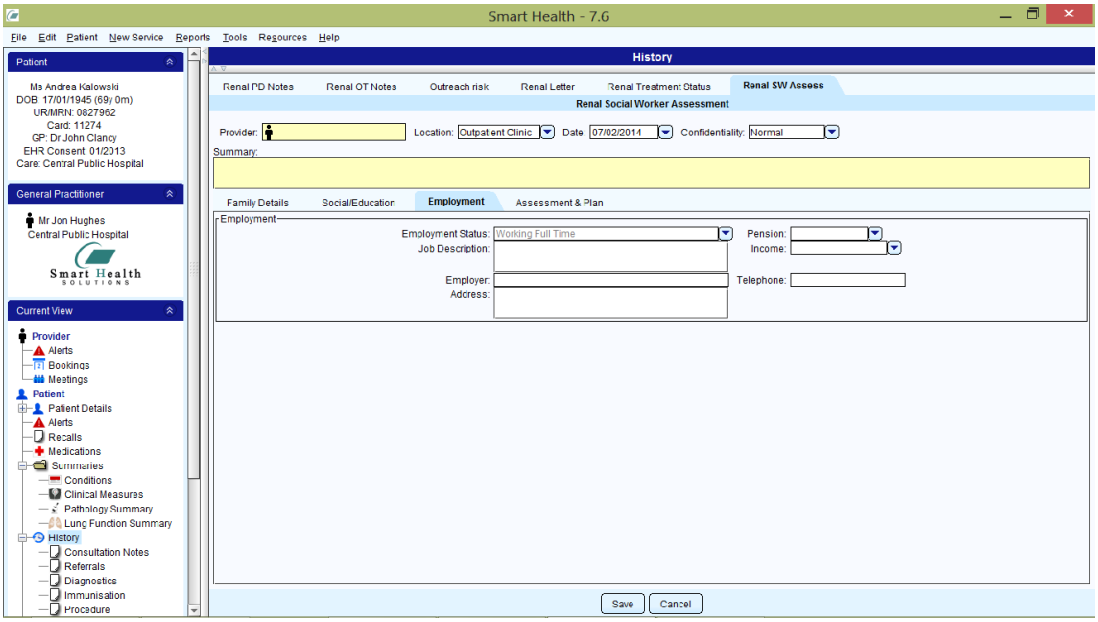
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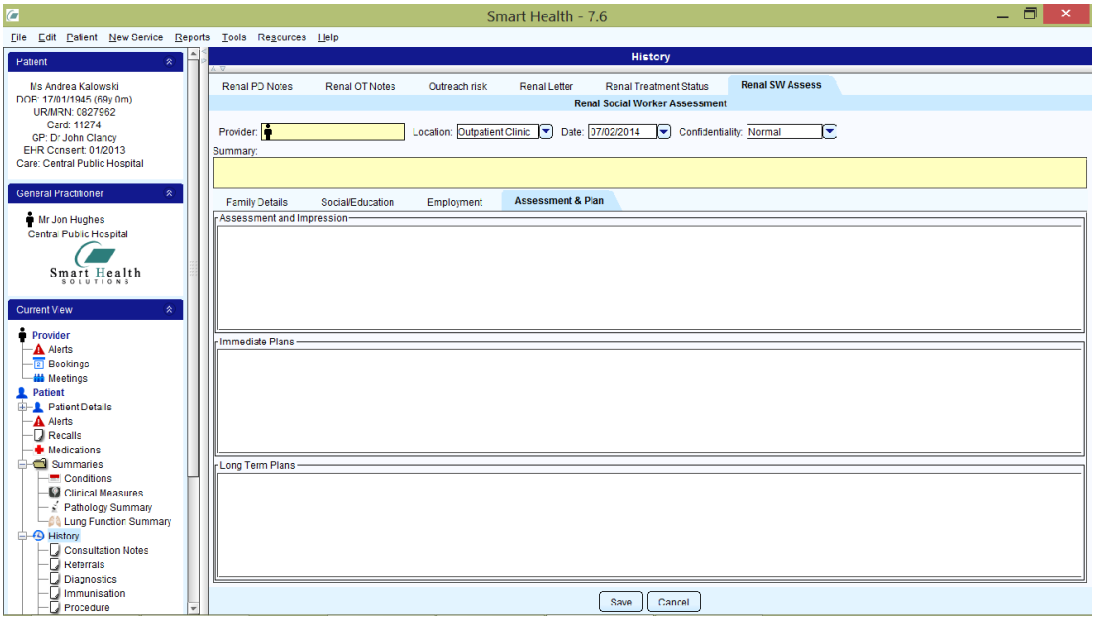
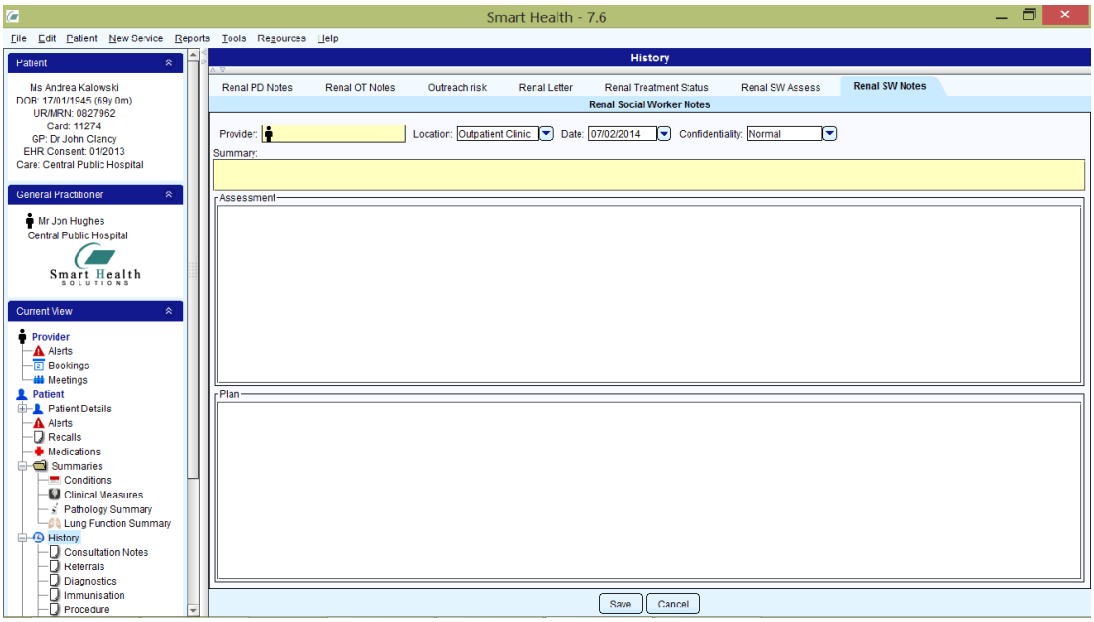
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Renal PD Notes
Renal OT Notes
Outreach risk
Renal Letter
Renal Treatment Status
Renal SW Assess
Renal Social Worker Assessment
Provider:
Location: Outpatient Clinic
Date: 07/02/2014
Confidentiality: Normal
Summary:
Family Details
Social/Education
Employment
Assessment & Plan
Employment
Employment Status: Working Full Time
Job Description:
Employer:
Address:
Pension:
Income:
Telephone:
Save
Cancel

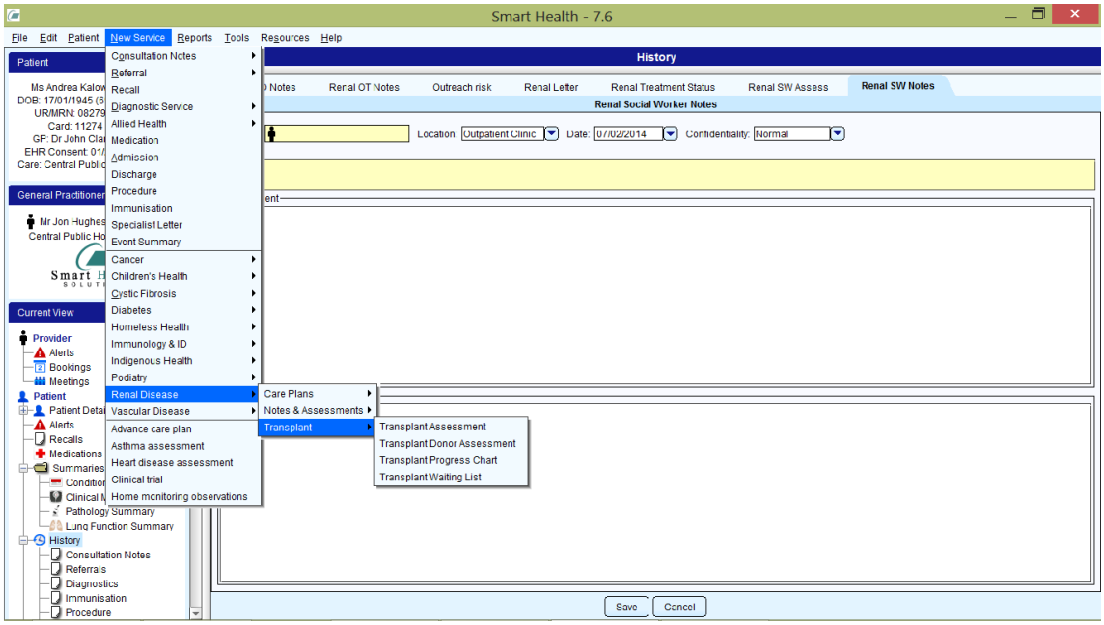


11.4.3.15 Social Worker Notes

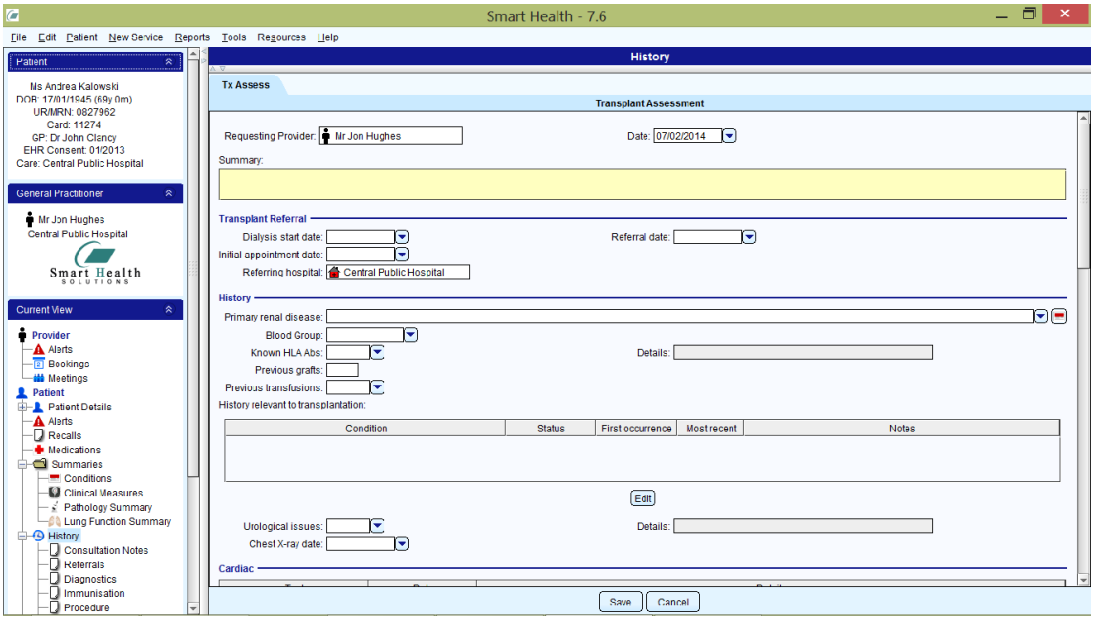


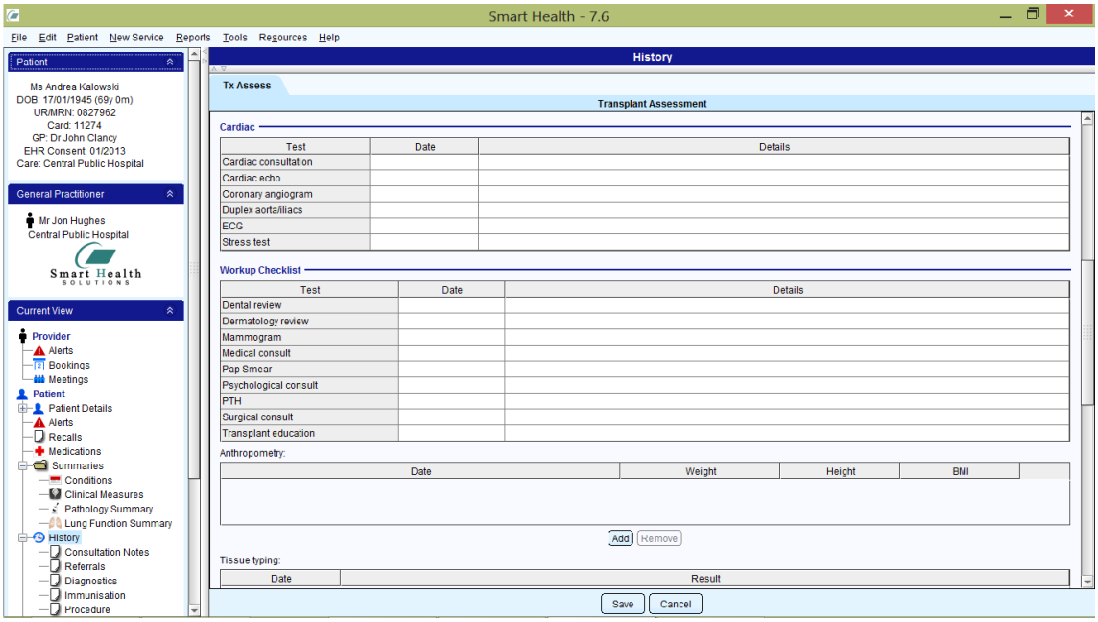
11.4.4 Transplant

Select New Service/Renal Disease/Transplant to create renal patient transplant assessments and care plans:



11.4.4.1 Transplant Assessment




Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
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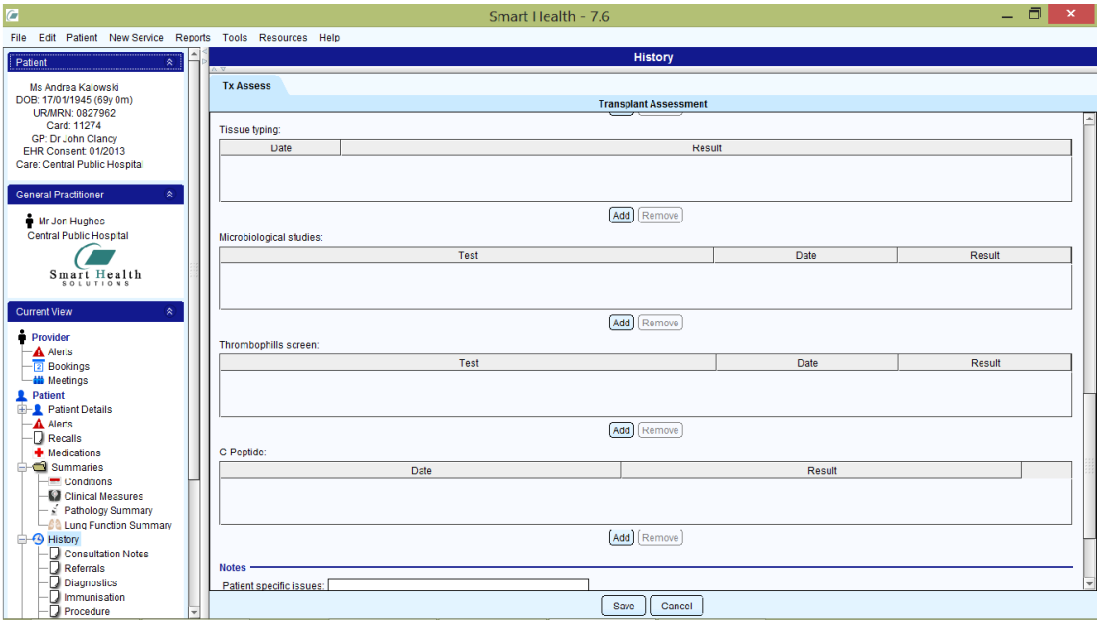
Diagnostics
Immunisation
Procedure
History
Tx Assess
Transplant Assessment
Cardiac
Test
Date
Details
Cardiac consultation
Cardiac echo
Coronary angiogram
Duplex aorta/iliacs
ECG
Stress test
Workup Checklist
Test
Date
Details
Dental review
Dermatology review
Mammogram
Medical consult
Pap Smear
Psychological consult
PTH
Surgical consult
Transplant education
Anthropometry:
Date
Weight
Height
BMI
Add
Remove
Tissue typing:
Date
Result
Save
Cancel


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
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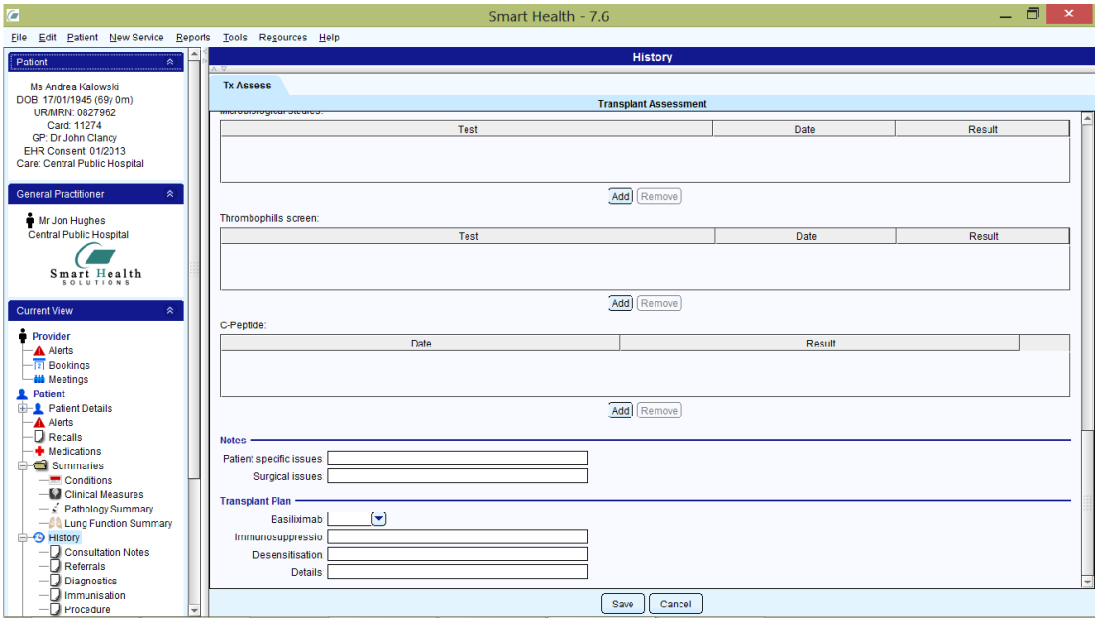
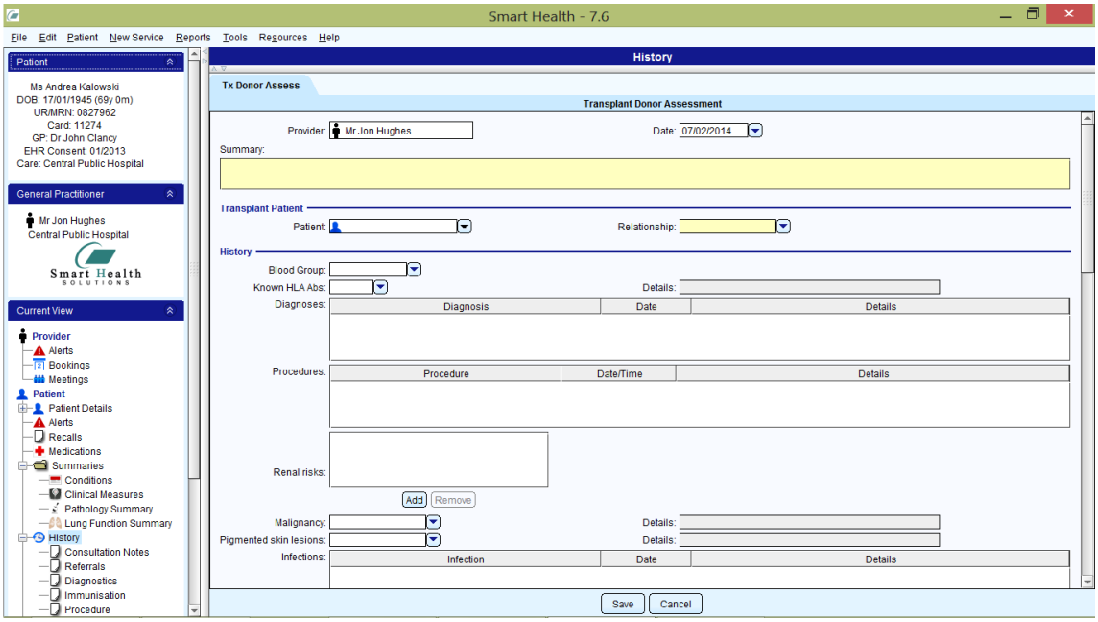
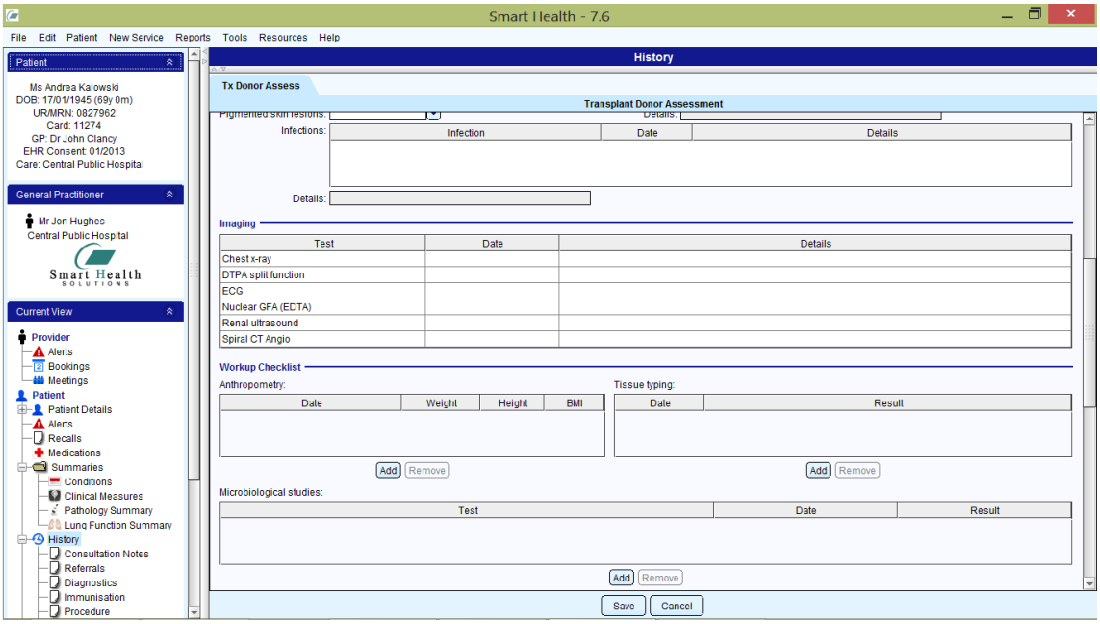
Immunisation
Procedure
History
Tx Assess
Transplant Assessment
Tissue typing:
Date
Result
Add
Remove
Microbiological studies:
Test
Date
Result
Add
Remove
Thrombophilia screen:
Test
Date
Result
Add
Remove
C Peptide:
Date
Result
Add
Remove
Notes
Patient specific issues:
Save
Cancel



11.4.4.2 Transplant Donor Assessment

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File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
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General Practitioner
Mr Jon Hughes
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Diagnostics
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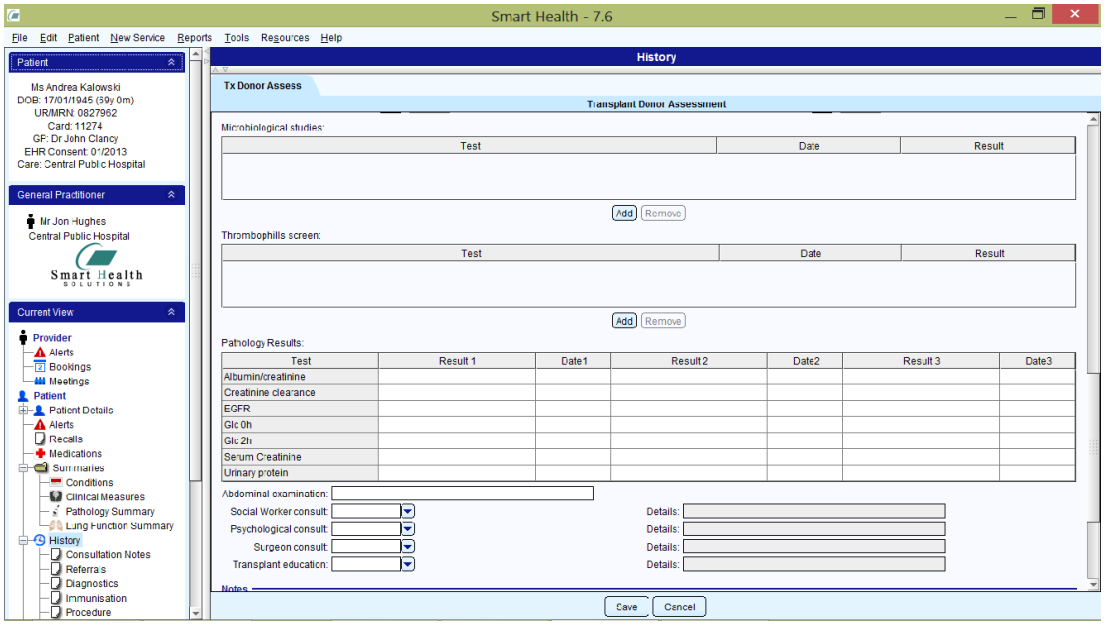
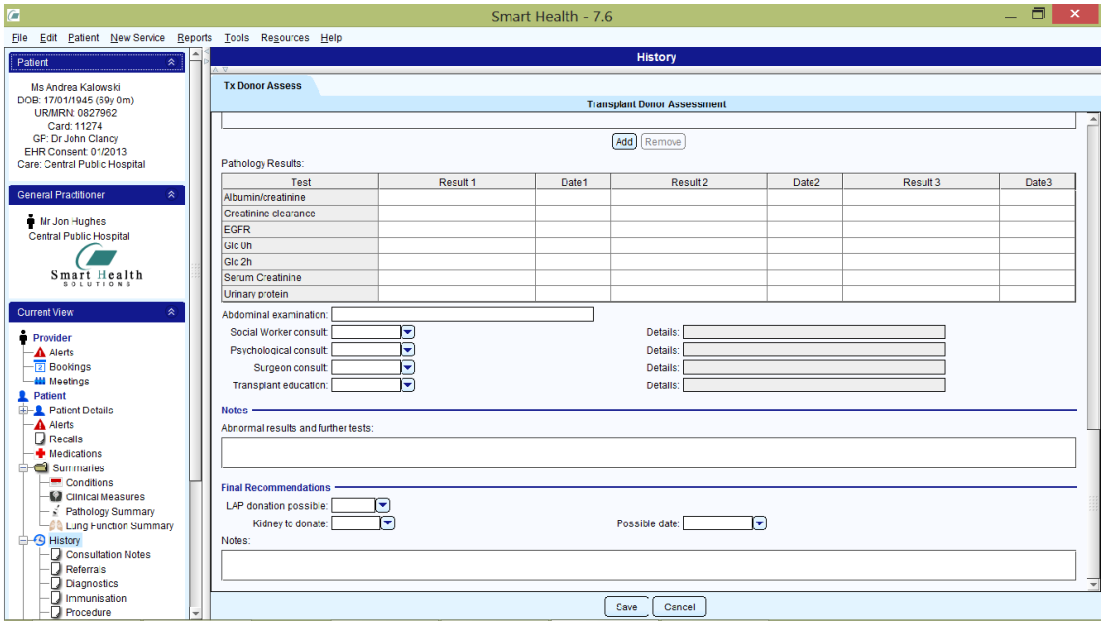
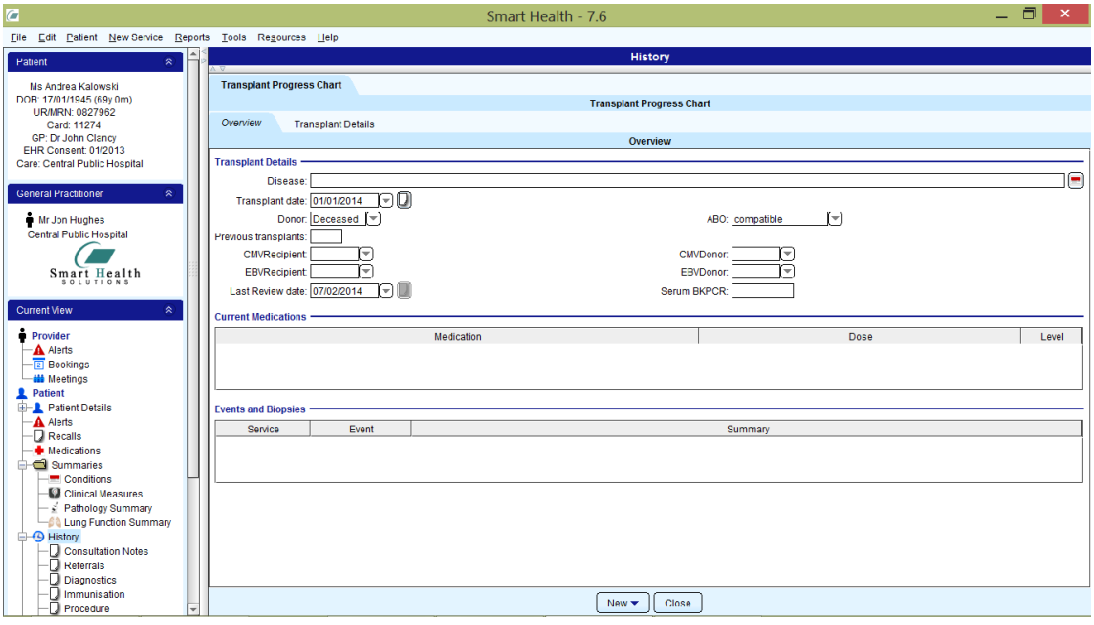
Procedure
History
Tx Donor Assess
Transplant Donor Assessment
Infections:
Infection
Date
Details
Details:
Imaging
Test
Date
Details
Chest x-ray
DTPA split function
ECG
Nuclear GFA (ECTA)
Renal ultrasound
Spiral CT Angio
Workup Checklist
Anthropometry:
Date
Weight
Height
BMI
Tissue typing:
Date
Result
Add
Remove
Microbiological studies:
Test
Date
Result
Save
Cancel

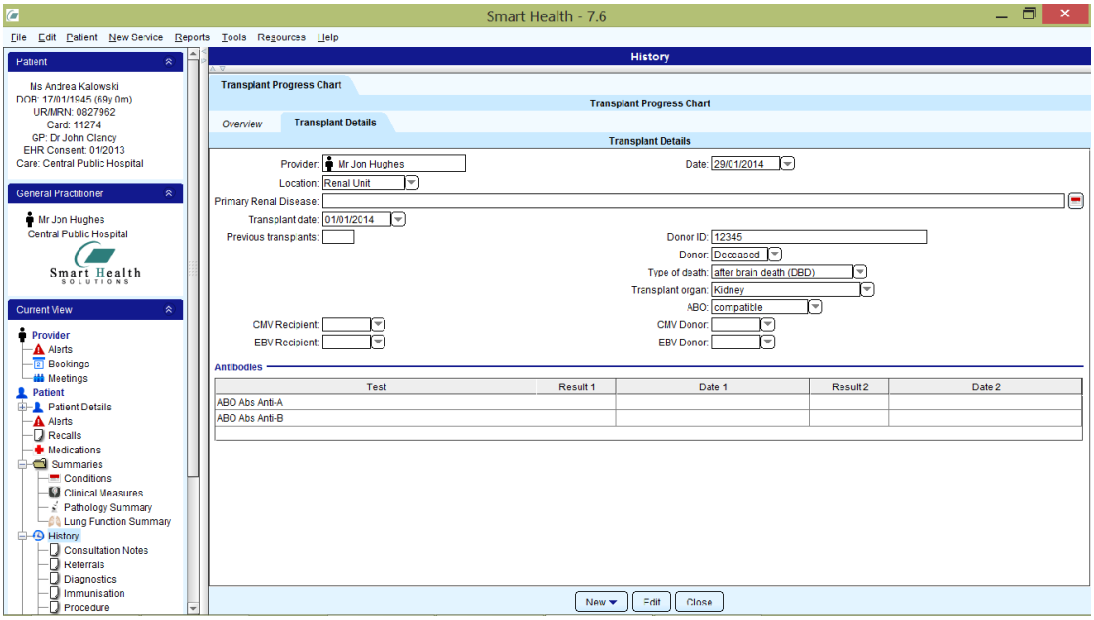

Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
History
Tx Donor Assess
Transplant Donor Assessment
Microbiological studies:
Test
Date
Result
Thrombophilia screen:
Pathology Results:
Test
Result 1
Date1
Result 2
Date2
Result 3
Date3
Albumin/creatinine
Creatinine clearance
EGFR
Glc 0h
Glc 2h
Serum Creatinine
Urinary protein
Abdominal examination:
Social Worker consult:
Psychological consult:
Surgeon consult:
Transplant education:
Details:
Notes
Save
Cancel



11.4.4.3 Transplant Progress Chart

The Transplant Progress Chart records transplant details, plus follow up microbiological and medication reviews, biopsies and reportable ANZDATA events. A read-only overview is provided as the first tab (default view).

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File Edit Patient New Service Reports Tools Resources Help
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Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
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EHR Consent: 01/2013
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General Practitioner
Mr Jon Hughes
Central Public Hospital
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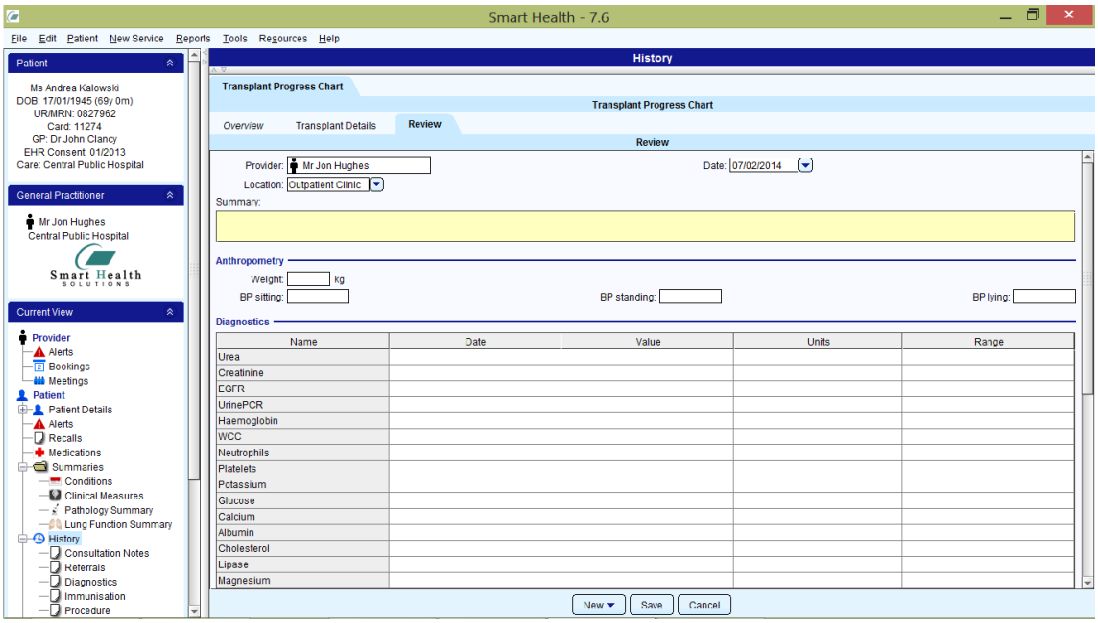
Referrals
Diagnostics
Immunisation
Procedure
History
Transplant Progress Chart
Transplant Progress Chart
Overview
Transplant Details
Transplant Details
Provider: Mr Jon Hughes
Date: 29/01/2014
Location: Renal Unit
Primary Renal Disease:
Transplant date: 01/01/2014
Previous transplants:
Donor ID: 12345
Donor: Deceased
Type of death: after brain death (DBD)
Transplant organ: Kidney
ABO: compatible
CMV Recipient:
EBV Recipient:
CMV Donor:
EBV Donor:
Antibodies
Test
Result 1
Date 1
Result 2
Date 2
ABO Abs Anti-A
ABO Abs Anti-B
New
Edit
Close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File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
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Transplant Progress Chart
Transplant Progress Chart
Overview
Transplant Details
Review
Review
Provider: Mr Jon Hughes
Date: 07/02/2014
Location: Outpatient Clinic
Summary:
Anthropometry
Weight: kg
BP sitting:
BP standing:
BP lying:
Diagnostics
Name
Date
Value
Units
Range
Urea
Creatinine
EGFR
UrinePCR
Haemoglobin
WCC
Neutrophils
Platelets
Pctassium
Glucose
Calcium
Albumin
Cholesterol
Lipase
Magnesium
New
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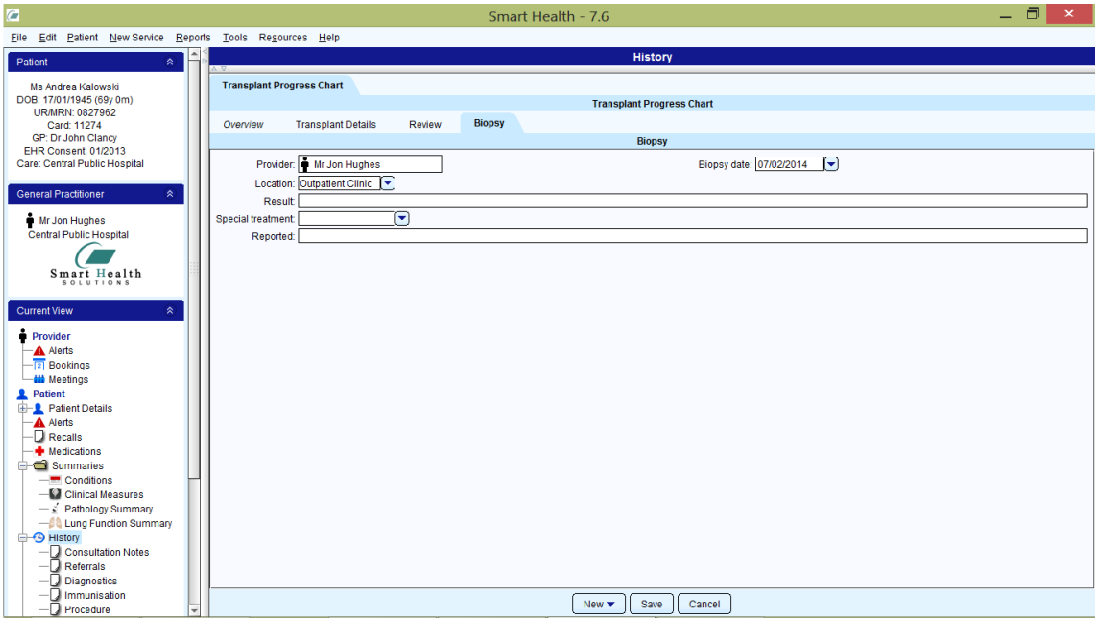
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DOB 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
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History
Transplant Progress Chart
Transplant Progress Chart
Overview
Transplant Details
Review
Biopsy
Biopsy
Provider: Mr Jon Hughes
Biopsy date: 07/02/2014
Location: Outpatient Clinic
Result:
Special Treatment:
Reported:
New
Save
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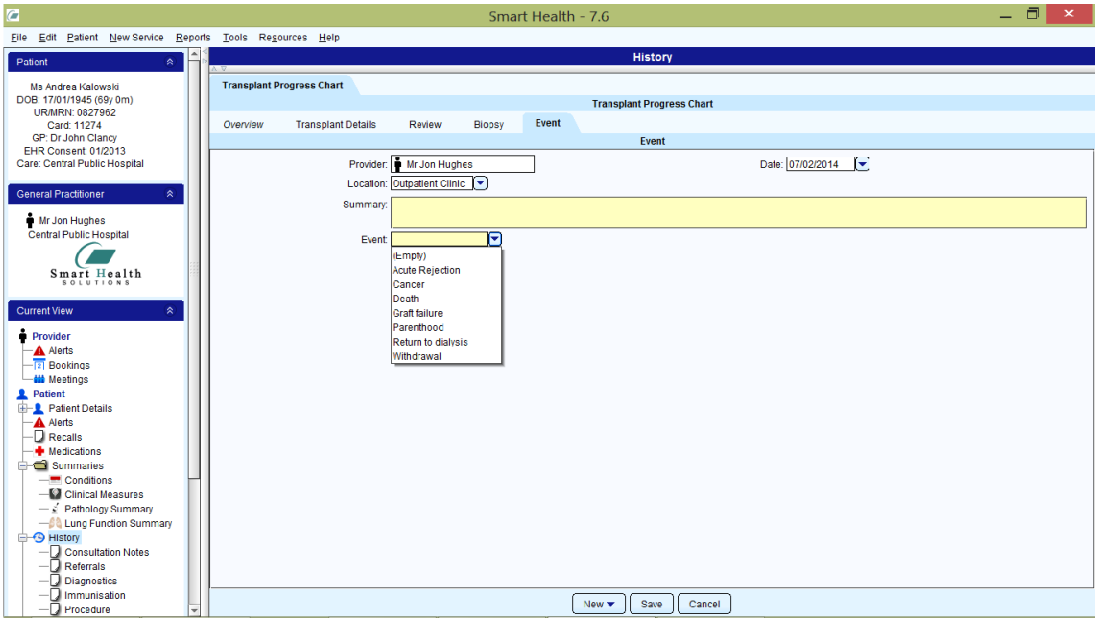
Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
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Ms Andrea Kalowski
DOB 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
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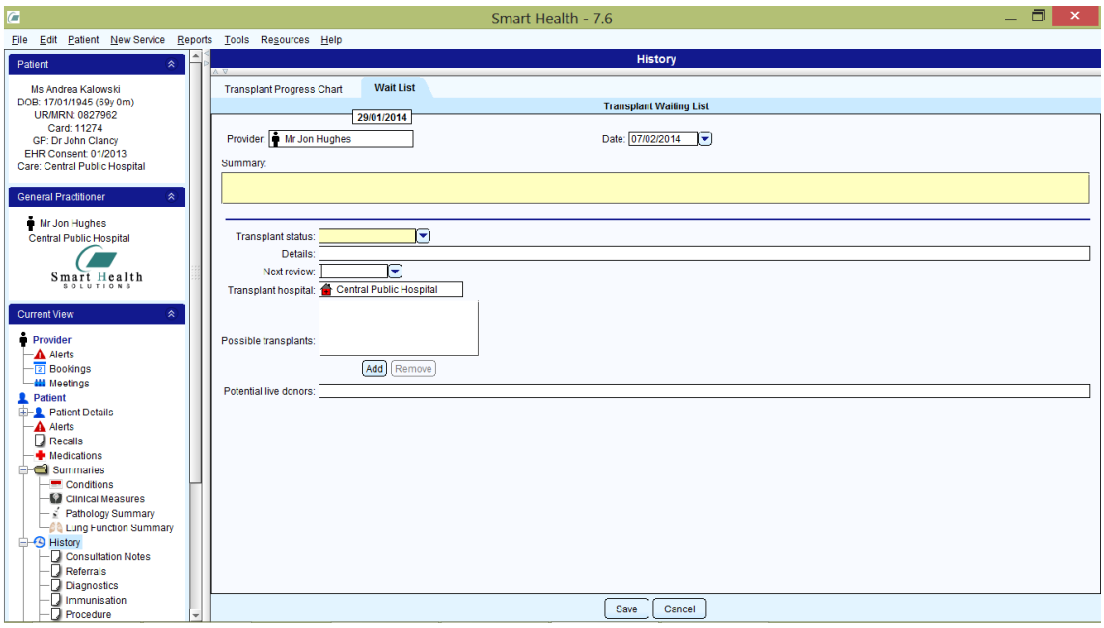
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
Transplant Progress Chart
Transplant Progress Chart
Overview
Transplant Details
Review
Biopsy
Event
Event
Provider: Mr Jon Hughes
Date: 07/02/2014
Location: Outpatient Clinic
Summary:
Event:
(Empty)
Acute Rejection
Cancer
Death
Graft failure
Parenthood
Return to dialysis
Withdrawal
New
Save
Cancel

11.4.4.4 Transplant Waiting List



11.5 Vascular Disease

The Vascular Disease program provides on-line forms for vascular studies and assessments, including graphical representation of vessels, diseases and procedures.

Templates are used to represent the blood vessels in various parts of the body. Each patient only has one set of health event records for a particular template; that is, once a template is selected, it used to create all future event summaries for that template, retaining blood vessel history throughout the life of the patient.

If you create a new vascular study or procedure using a template that has been used previously for the patient, you will automatically start with the current state of the vessels described in that template.

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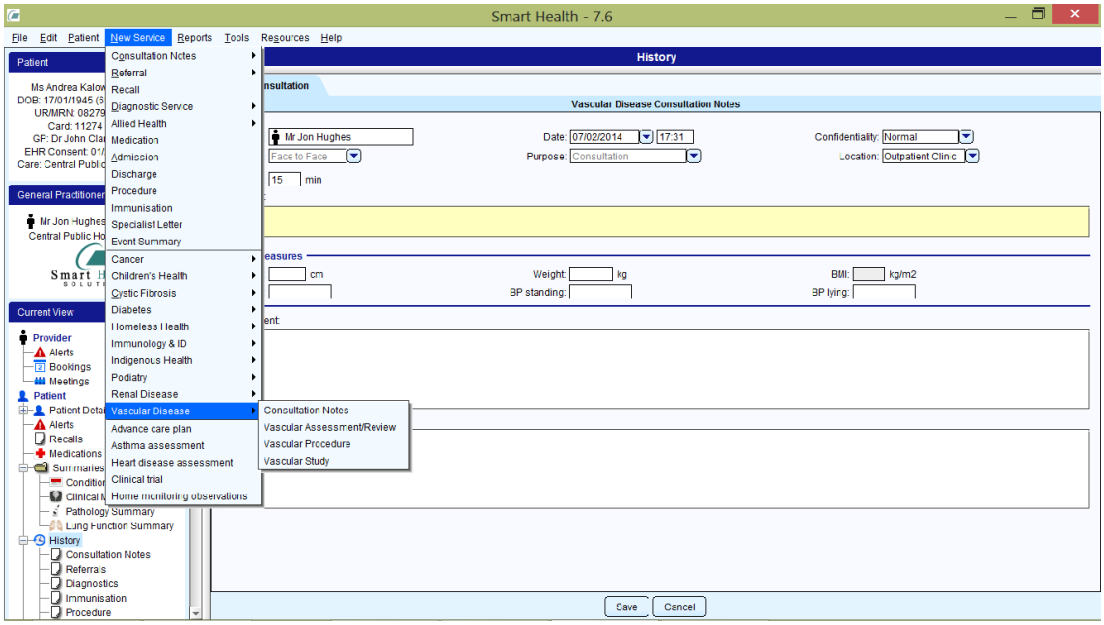
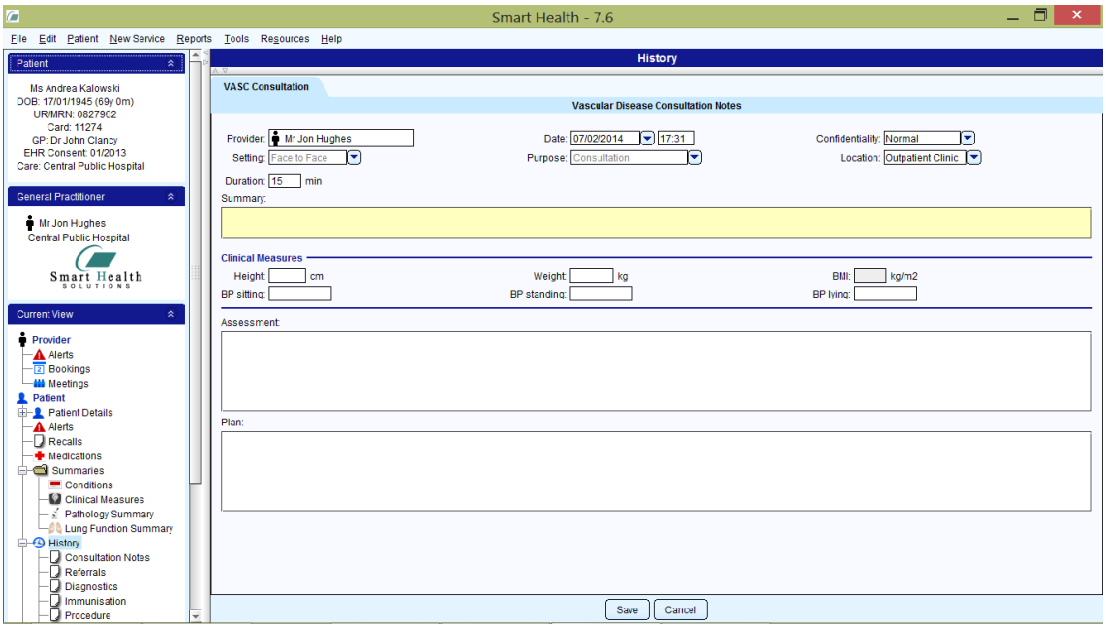


11.5.1 Vascular Consultation Note

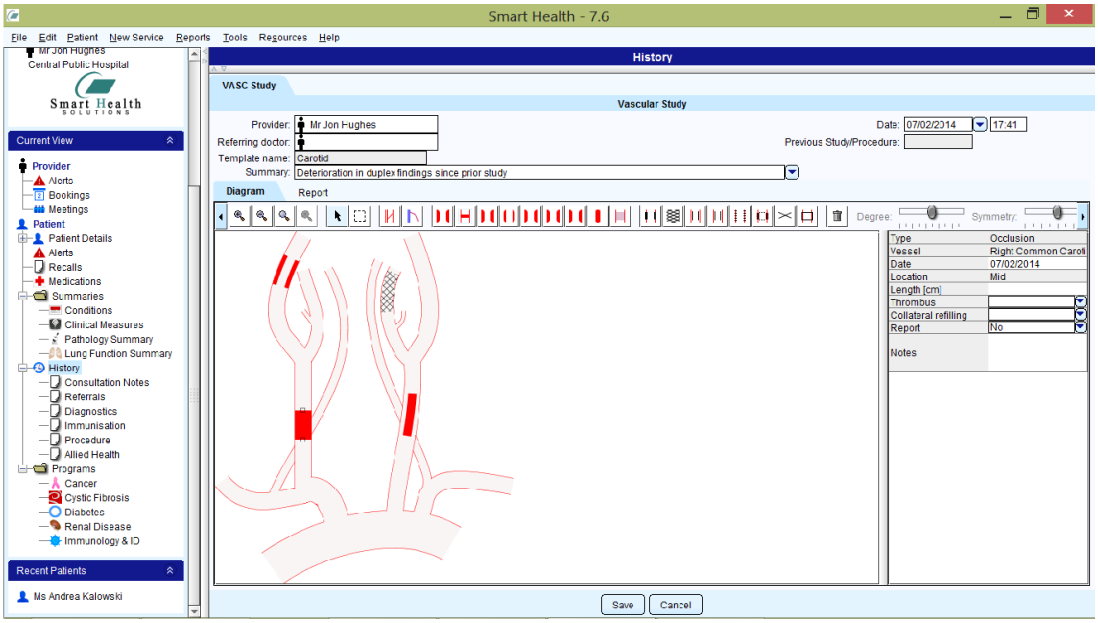


11.5.2 Vascular Study

A Vascular Study documents vascular disease as a series of annotations on a graphical representation of the affected blood vessels (for example, stenosis or thrombosis).

Several graphical templates cover all of the body's major vessels.

Select a diagram to display a graphical template that can be used to record the patient's vascular diagnoses and previous procedures. Each annotation (problem or disease) is described by a number of characteristics that are associated with the annotation. Findings are automatically assembled into Conclusions that can be edited and printed in a report of the study.



11.5.3 Vascular Procedure

A Vascular Procedure documents vascular disease as annotations on a graphical representation of the affected blood vessels (for example, a stent or graft). Several graphical templates cover all of the body's major vessels.

Each annotation (procedure) is described by a number of characteristics that are associated with the annotation. Findings are automatically assembled into Conclusions that can be edited and printed in a report of the procedure.

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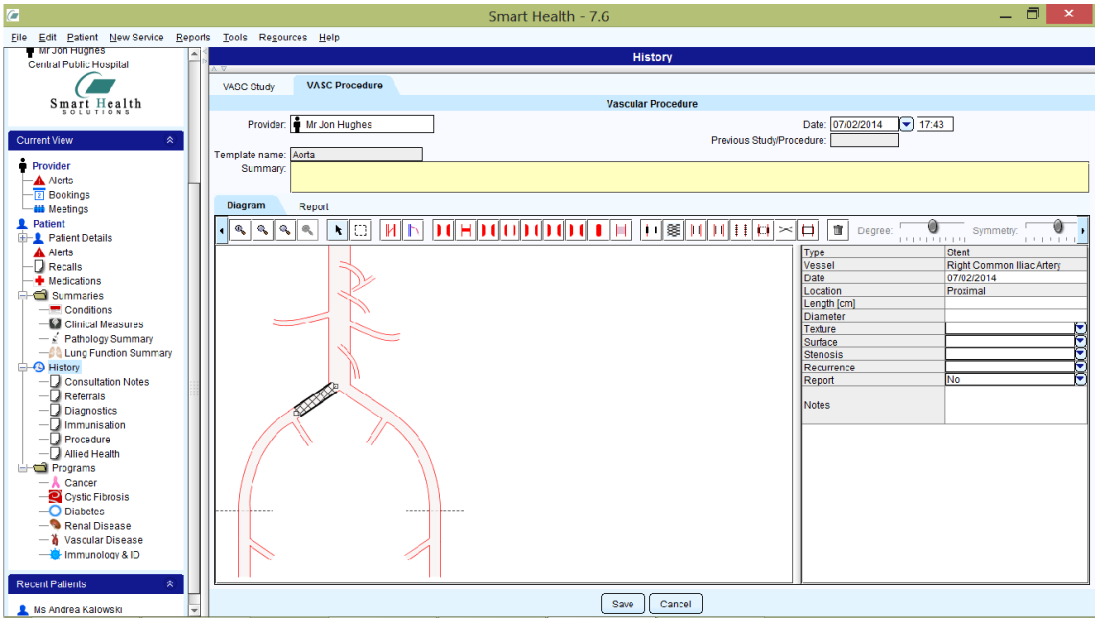
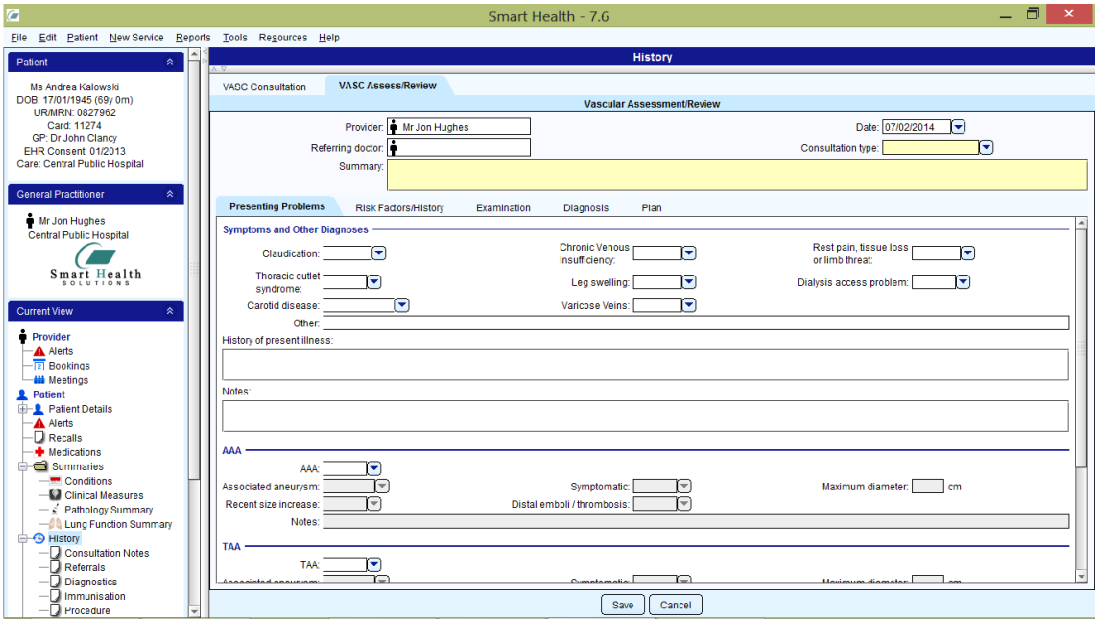
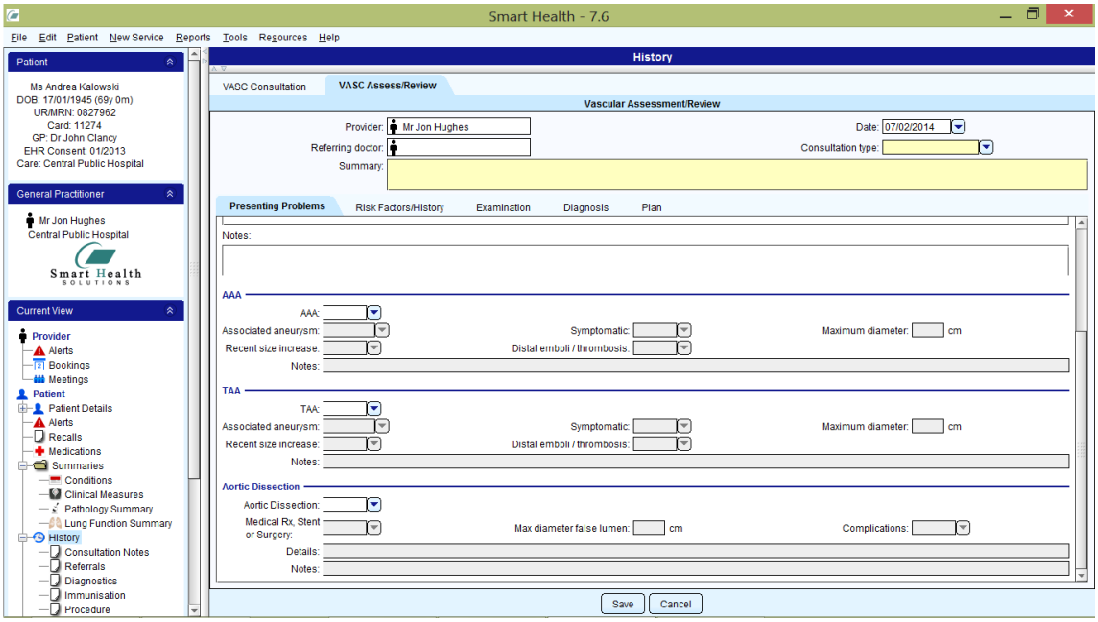


11.5.4 *Vascular Assessment/Review*

Vascular Assessments are used to assess and review the key indicators for vascular disease for a patient.




Smart Health - 7.6
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Ms Andrea Kalowski
DOB 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
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Immunisation
Procedure
History
VAQC Consultation
VASC Assess/Review
Vascular Assessment/Review
Provider: Mr Jon Hughes
Referring doctor:
Summary:
Date: 07/02/2014
Consultation type:
Presenting Problems
Risk Factors/History
Examination
Diagnosis
Plan
Notes:
AAA
AAA:
Associated aneurysm:
Recent size increase:
Symptomatic:
Distal emboli / thrombosis:
Maximum diameter: cm
Notes:
TAA
TAA:
Associated aneurysm:
Recent size increase:
Symptomatic:
Distal emboli / thrombosis:
Maximum diameter: cm
Notes:
Aortic Dissection
Aortic Dissection:
Medical Rx, Stent or Surgery:
Max diameter false lumen: cm
Complications:
Details:
Notes:
Save
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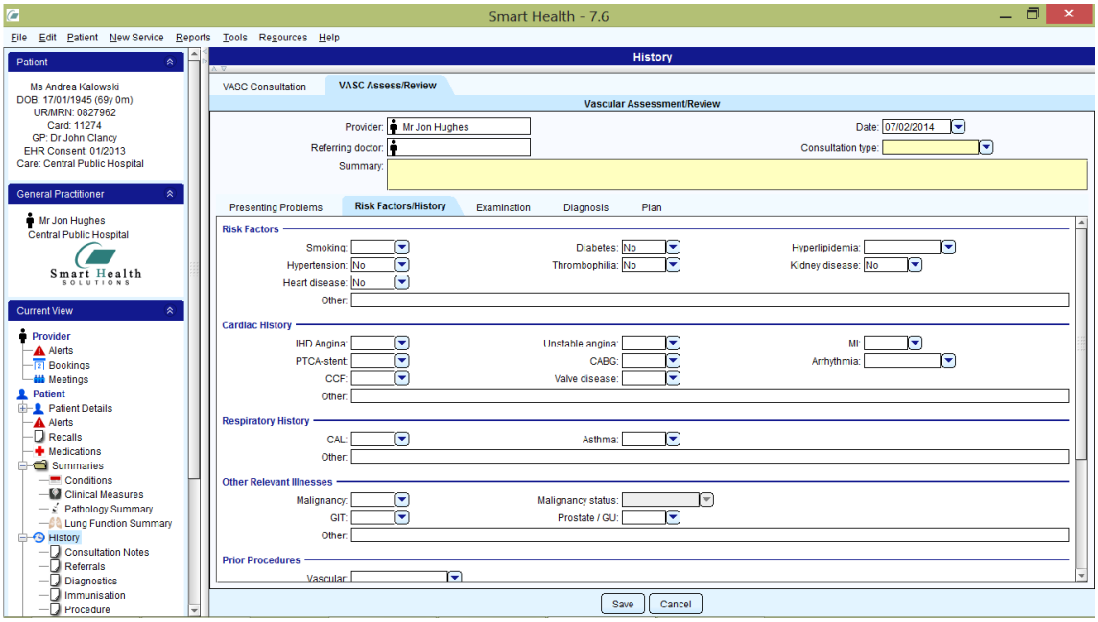
Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
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UR/MRN: 0827962
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History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
VAQC Consultation
VASC Assess/Review
Vascular Assessment/Review
Provider: Mr Jon Hughes
Referring doctor:
Summary:
Date: 07/02/2014
Consultation type:
Presenting Problems
Risk Factors/History
Examination
Diagnosis
Plan
Risk Factors
Smoking:
Hypertension: No
Heart disease: No
Diabetes: No
Thrombophilia: No
Hyperlipidemia:
Kidney disease: No
Other:
Cardiac History
IHD Angina:
PTCA-stent:
CCF:
Unstable angina:
CABG:
Valve disease:
MI:
Arrhythmia:
Other:
Respiratory History
CAL:
Asthma:
Other:
Other Relevant Illnesses
Malignancy:
GIT:
Malignancy status:
Prostate / GU:
Other:
Prior Procedures
Vascular:
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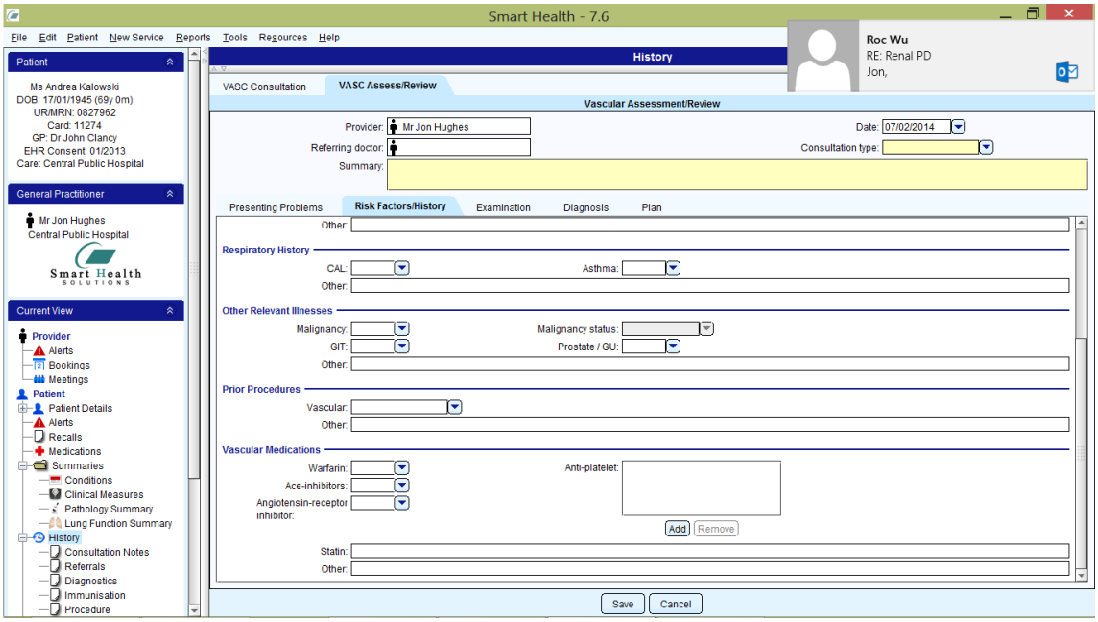
Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
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EHR Consent: 01/2013
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General Practitioner
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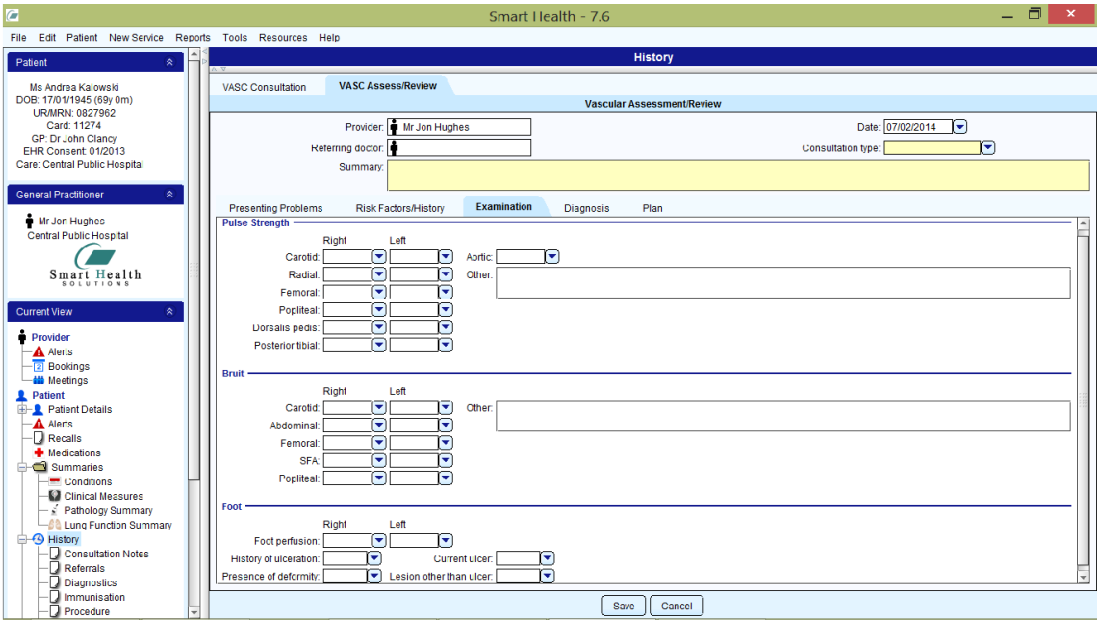
Referrals
Diagnostics
Immunisation
Procedure
History
VASC Consultation
VASC Assess/Review
Vascular Assessment/Review
Provicer: Mr Jon Hughes
Referring docor:
Summary:
Date: 07/02/2014
Consultation type:
Presenting Problems
Risk Factors/History
Examination
Diagnosis
Plan
Other:
Respiratory History
CAL:
Asthma:
Other:
Other Relevant Illnesses
Malignancy:
Malignancy status:
GIT:
Prostate / GU:
Other:
Prior Procedures
Vascular:
Other:
Vascular Medications
Warfarin:
Ace-inhibitors:
Angiotensin-receptor inhibitor:
Anti-platelet:
Add
Remove
Statin:
Other:
Save
Cancel
Roc Wu
RE: Renal PD
Jon,


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
Current View
Provider
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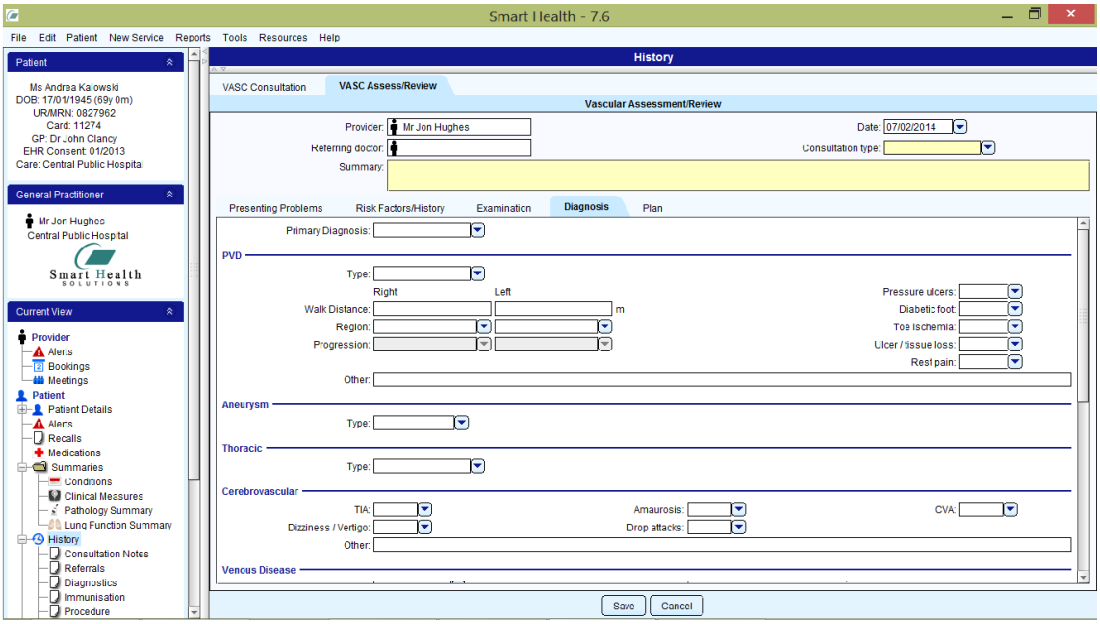
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
VASC Consultation
VASC Assess/Review
Vascular Assessment/Review
Provicer: Mr Jon Hughes
Referring docor:
Summary:
Date: 07/02/2014
Consultation type:
Presenting Problems
Risk Factors/History
Examination
Diagnosis
Plan
Pulse Strength
Right
Left
Carotid:
Aortic:
Radial:
Other:
Femoral:
Popliteal:
Dorsalis pedis:
Posterior tibial:
Bruit
Right
Left
Carotid:
Other:
Abdominal:
Femoral:
SFA:
Popliteal:
Foot
Right
Left
Foot perfusion:
History of ulceration:
Current Ulcer:
Presence of deformity:
Lesion other than Ulcer:
Save
Cancel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History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
History
VASC Consultation
VASC Assess/Review
Vascular Assessment/Review
Provider: Mr Jon Hughes
Referring doctor:
Date: 07/02/2014
Consultation type:
Summary:
Presenting Problems
Risk Factors/History
Examination
Diagnosis
Plan
Primary Diagnosis:
PVD
Type:
Right
Left
Walk Distance:
m
Region:
Progression:
Pressure ulcers:
Diabetic foot:
Toe Ischemia:
Ulcer / tissue loss:
Rest pain:
Other:
Aneurysm
Type:
Thoracic
Type:
Cerebrovascular
TIA:
Amaurosis:
CVA:
Dizziness / Vertigo:
Drop attacks:
Other:
Vencus Disease
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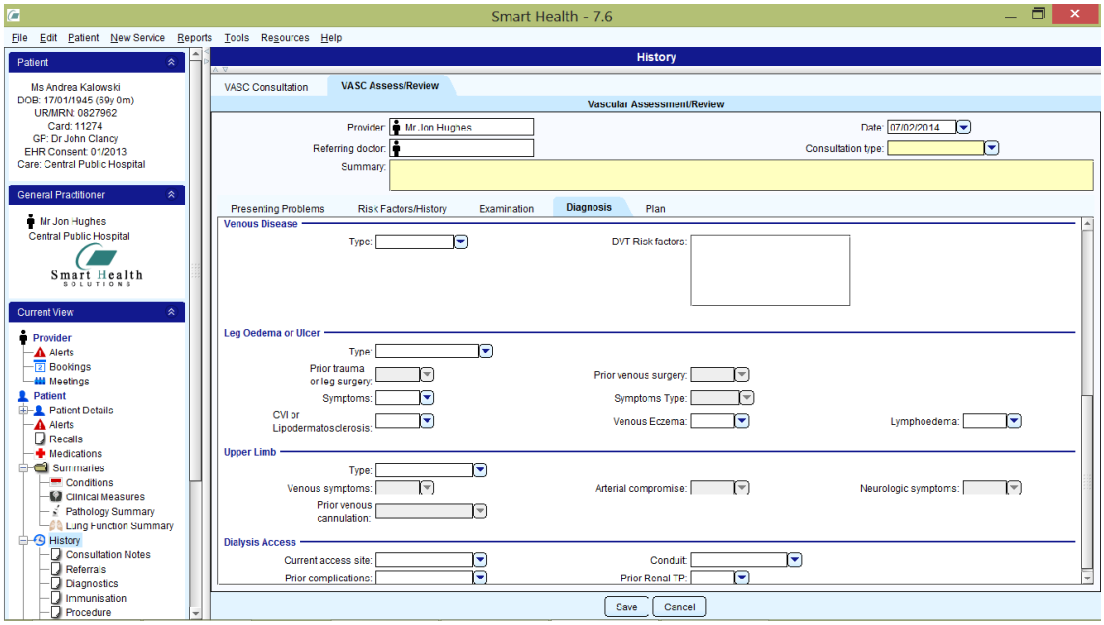
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Diagnostics
Immunisation
Procedure
History
VASC Consultation
VASC Assess/Review
Vascular Assessment/Review
Provider: Mr Jon Hughes
Referring doctor:
Date: 07/02/2014
Consultation type:
Summary:
Presenting Problems
Risk Factors/History
Examination
Diagnosis
Plan
Venous Disease
Type:
DVT Risk factors:
Leg Oedema or Ulcer
Type:
Prior trauma or leg surgery:
Prior venous surgery:
Symptoms:
Symptoms Type:
CVI or Lipodermatosclerosis:
Venous Eczema:
Lymphoedema:
Upper Limb
Type:
Venous symptoms:
Arterial compromise:
Neurologic symptoms:
Prior venous cannulation:
Dialysis Access
Current access site:
Conduit:
Prior complications:
Prior Renal TP:
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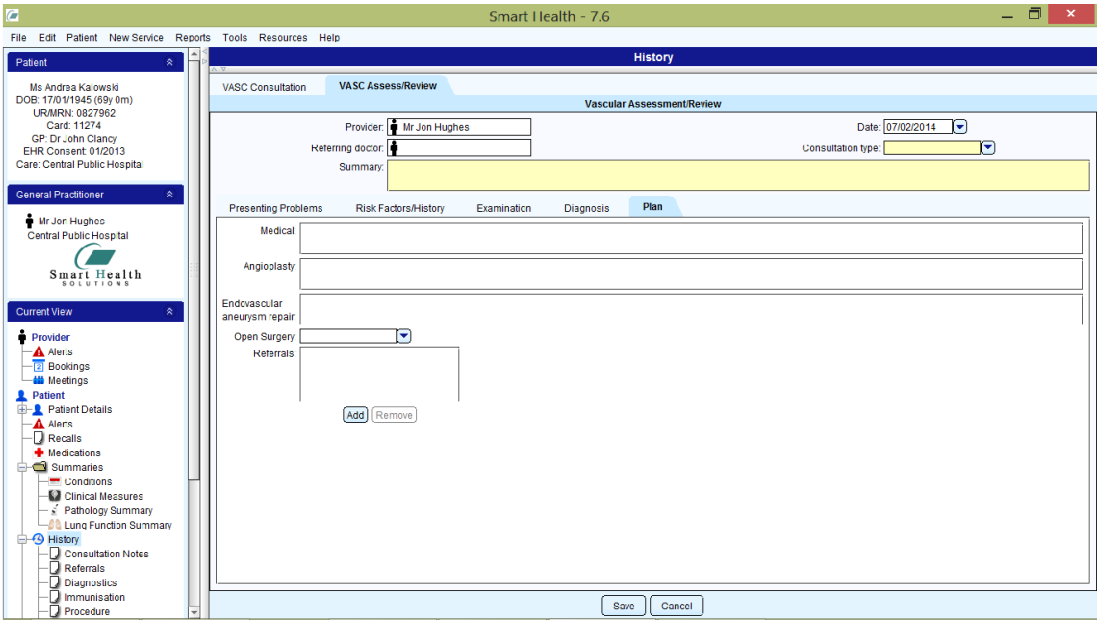
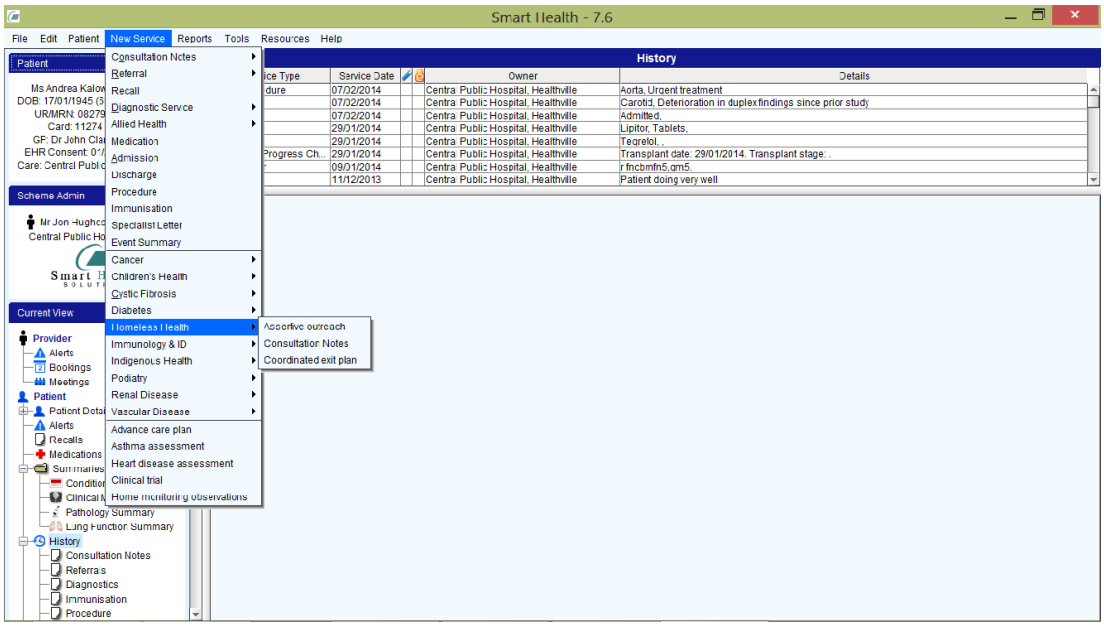
Cancel



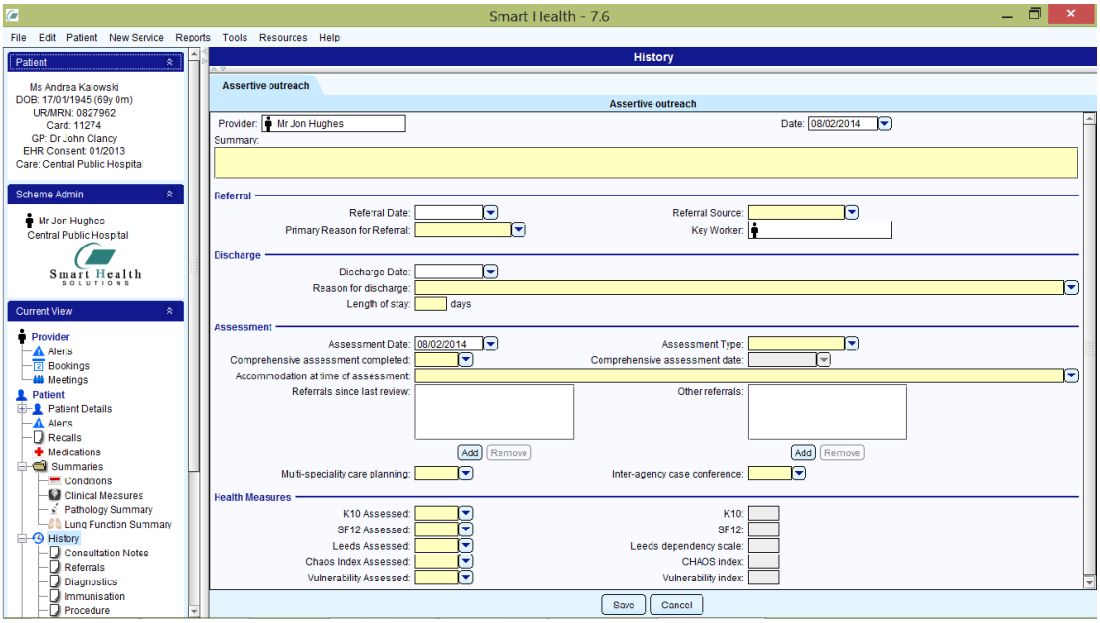
11.6 Homeless Health

The Homeless Health program captures clinical and management information for patients who are cared for by various community and non-government facilities.

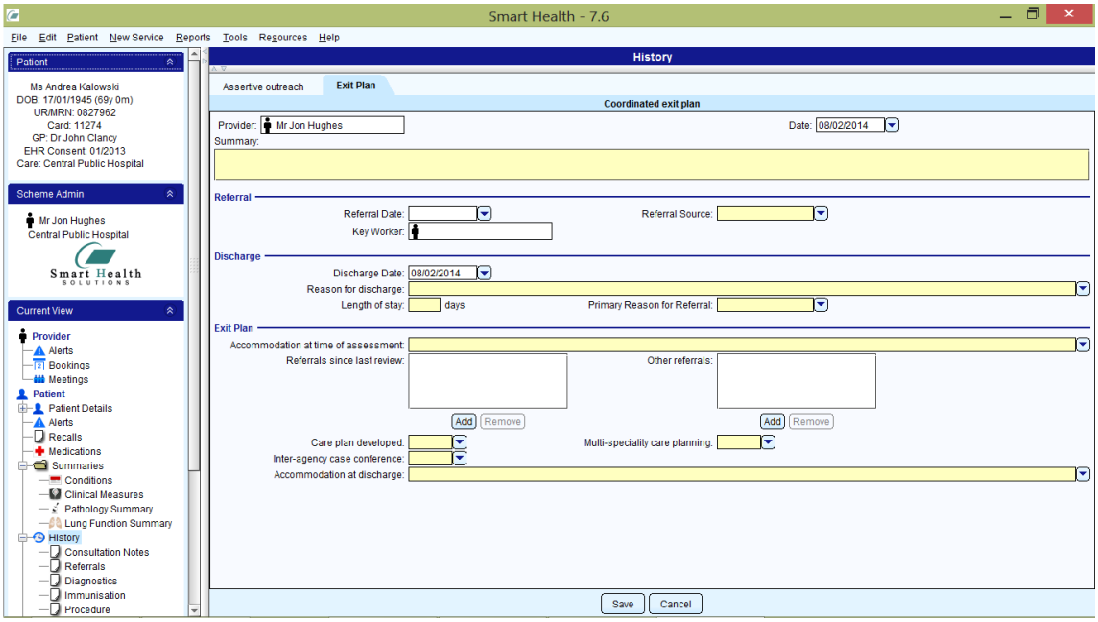
New clinical records are created from the New Service/Homeless Health menu:



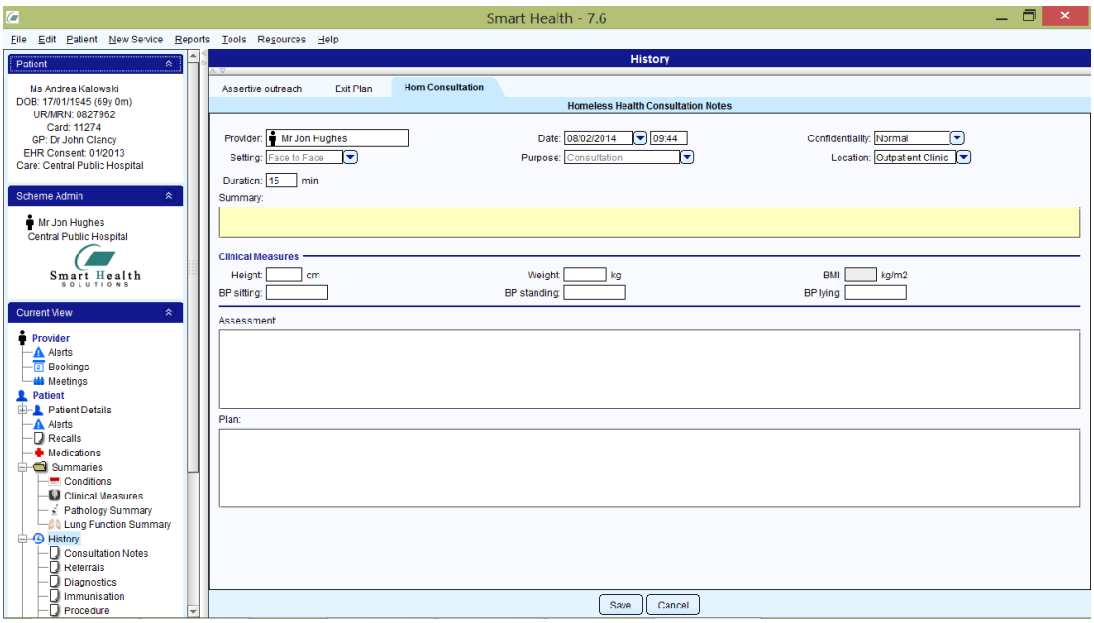
11.6.1 Assertive Outreach



11.6.2 Coordinated Exit Plan

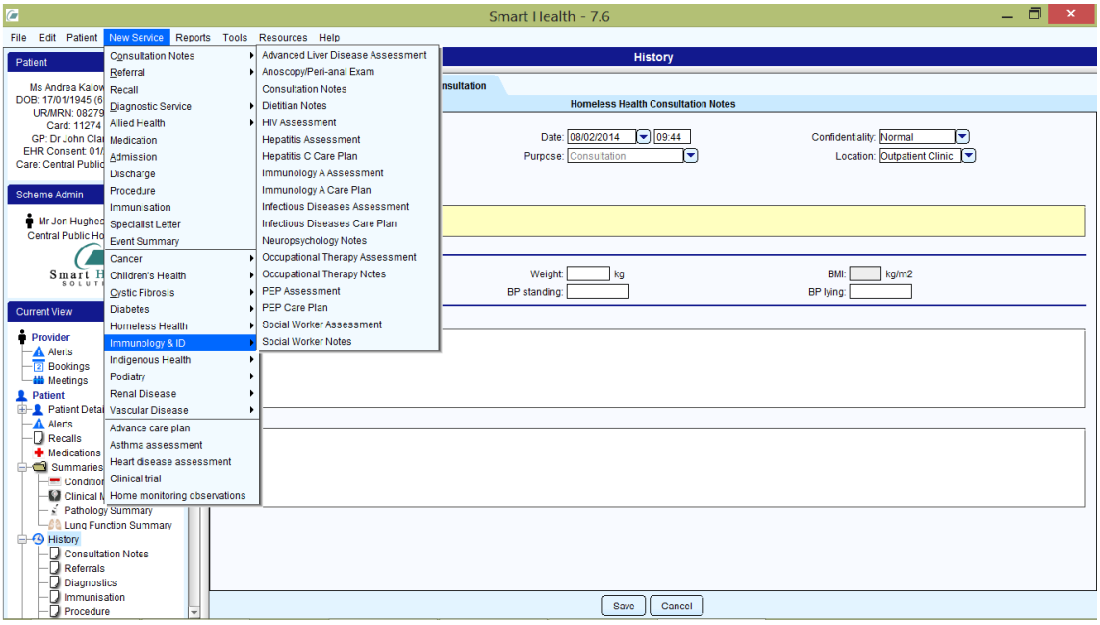


11.6.3 Consultation Note



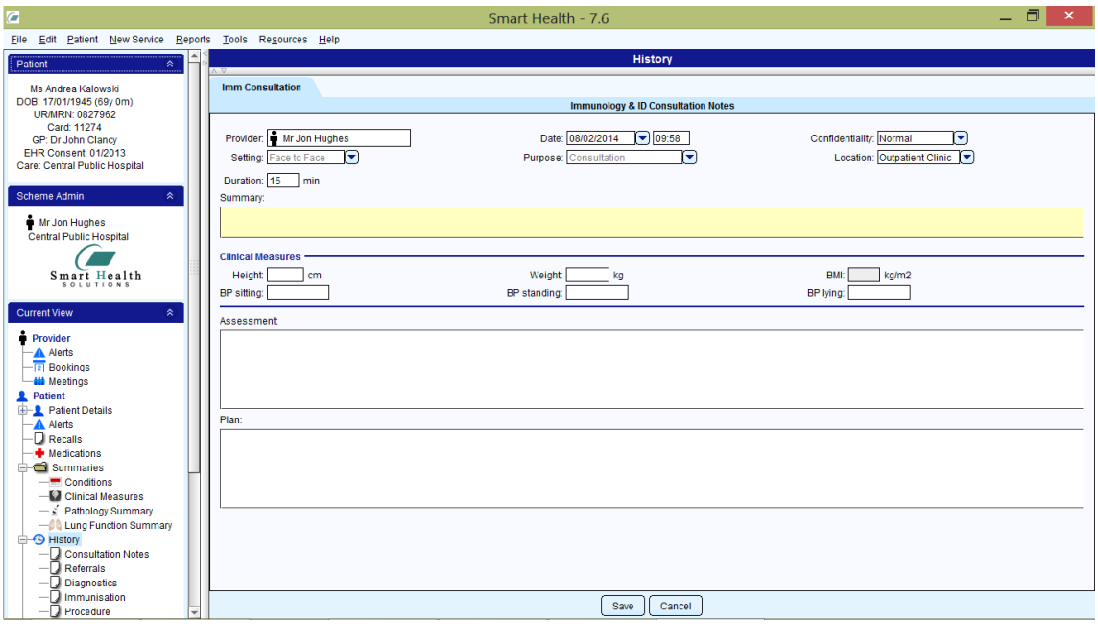
11.7 Immunology and Infectious Diseases

Immunology and Infectious Diseases service records are created from the New Service/Immunology and ID menu:



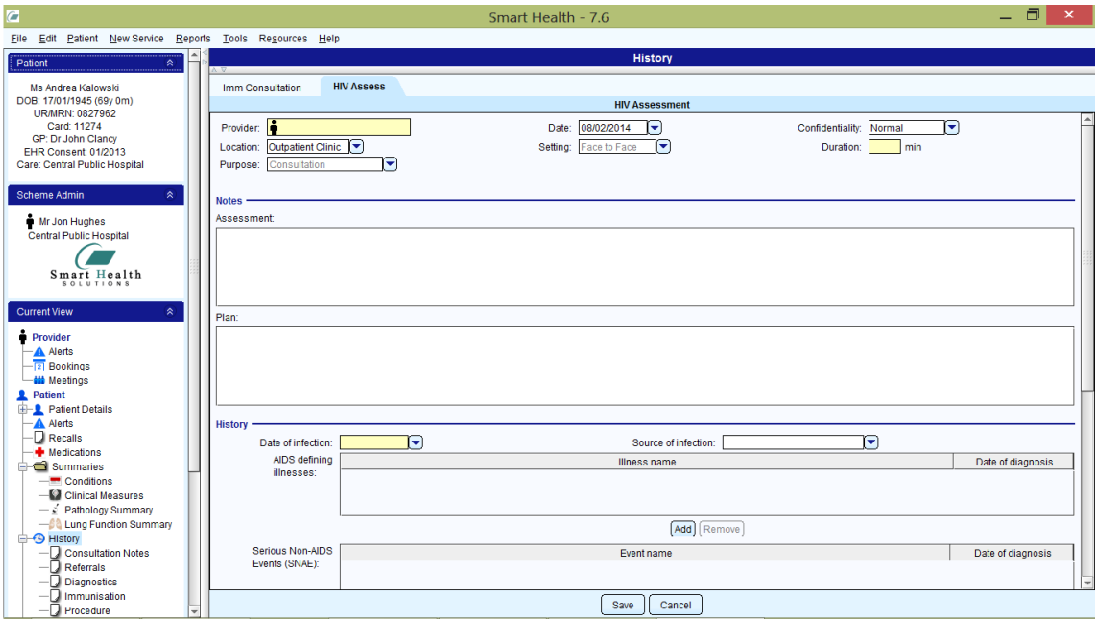
Each sub-group of Immunology and ID programs has its own read-only Summary view of clinical data for the patient.

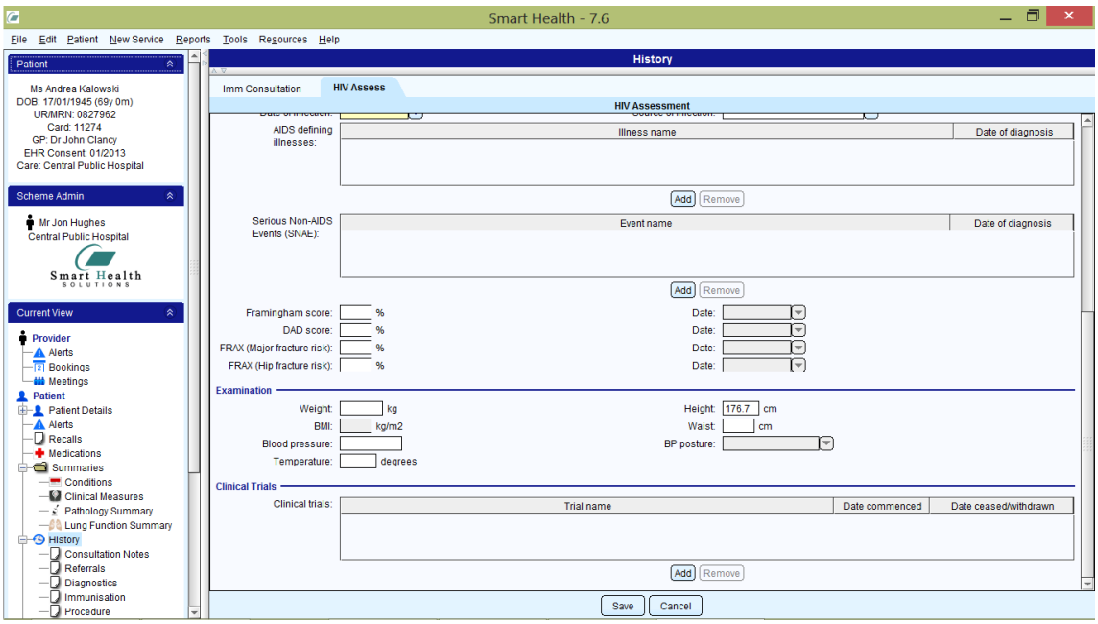
11.7.1 Consultation Notes



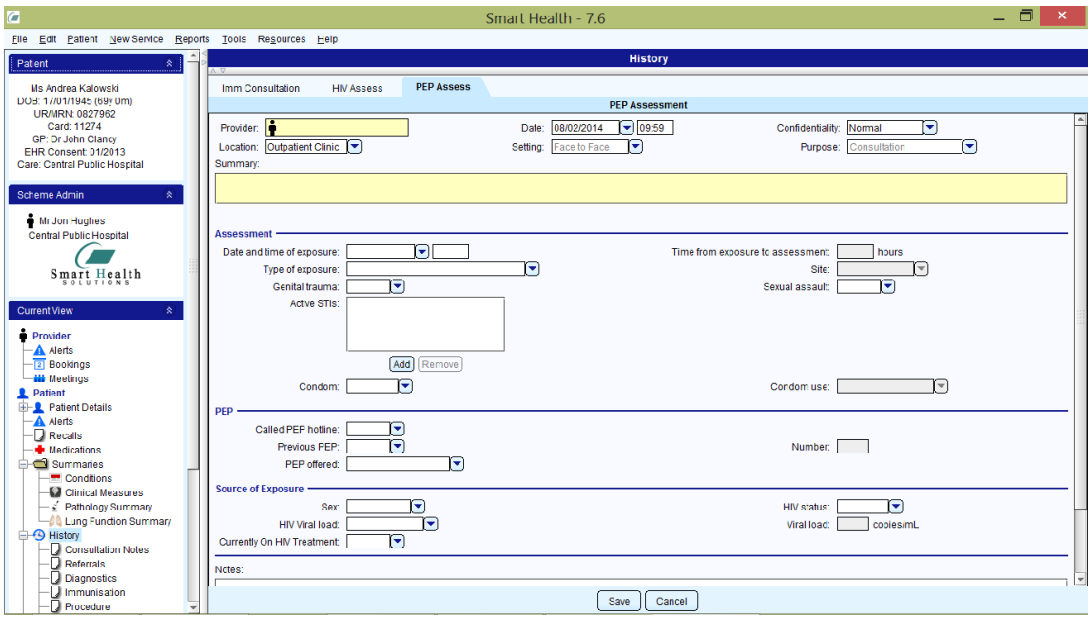
11.7.2 HIV

11.7.2.1 HIV Assessment

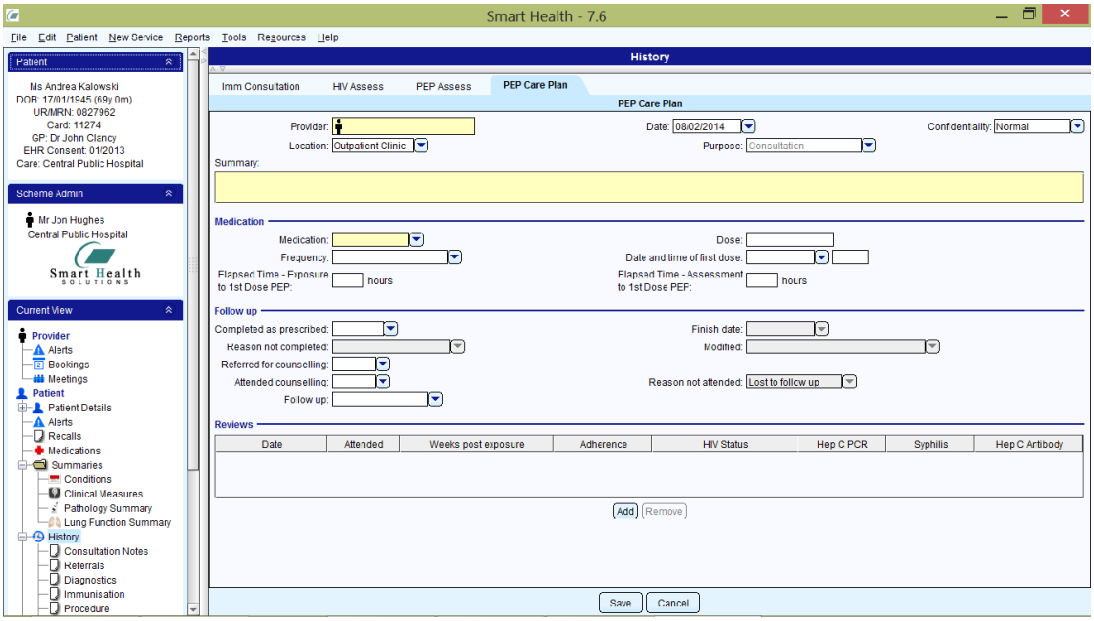




11.7.2.2 PEP Assessment

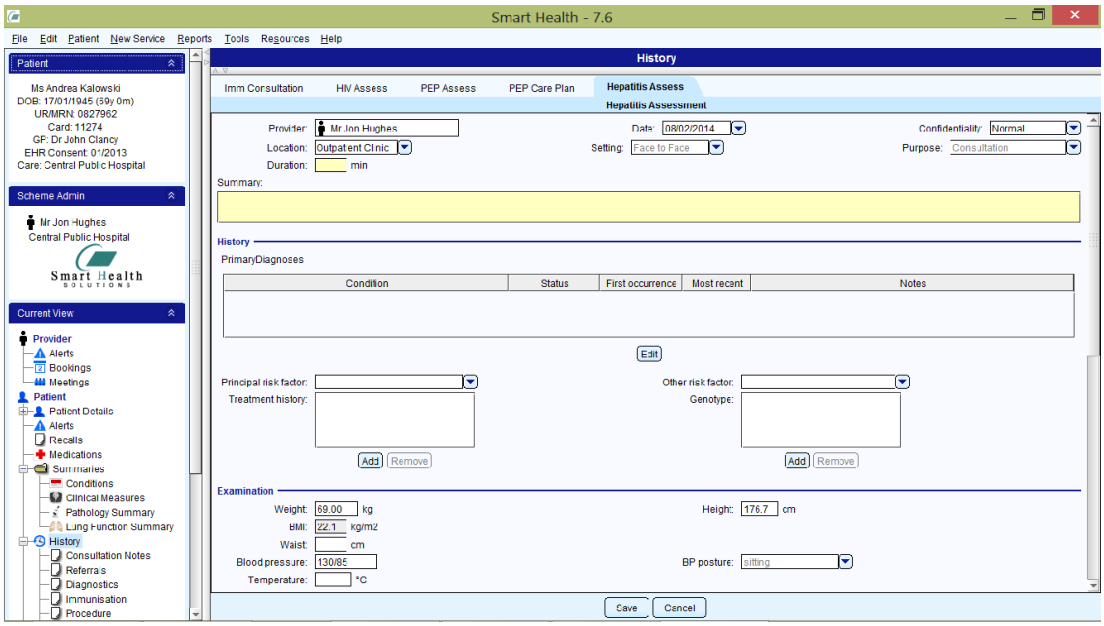


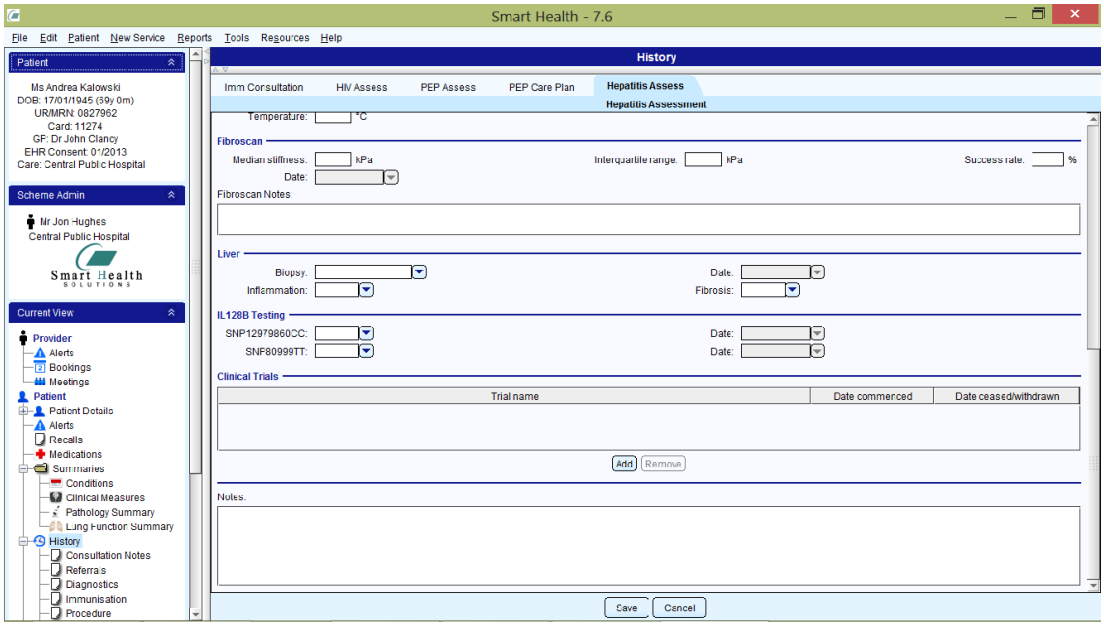
11.7.2.3 PEP Care Plan



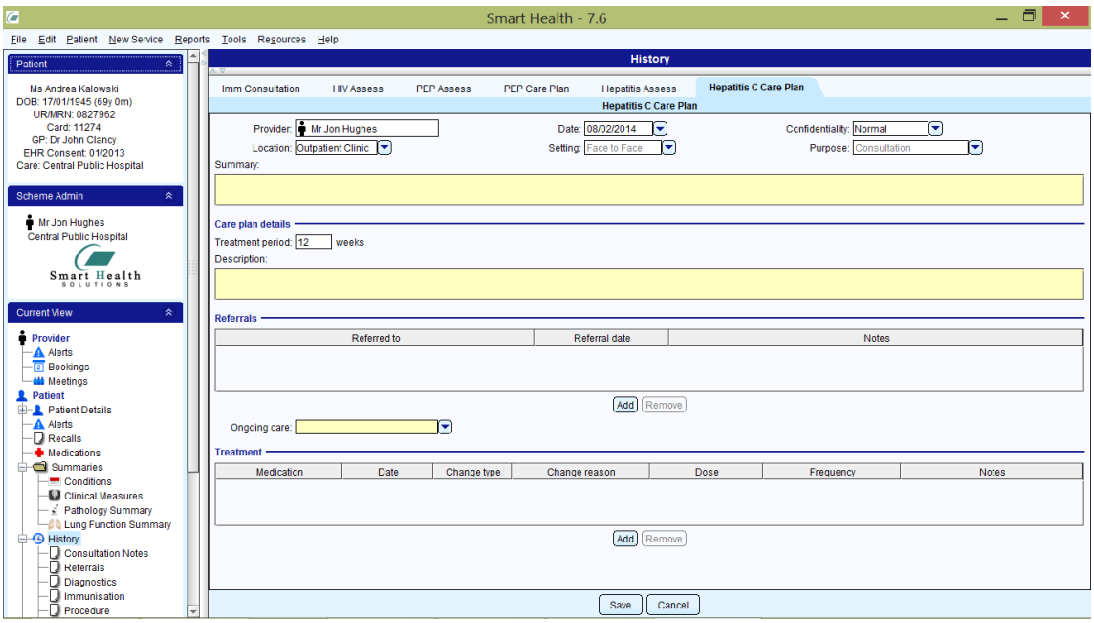
11.7.3 Hepatitis

11.7.3.1 Hepatitis Assessment

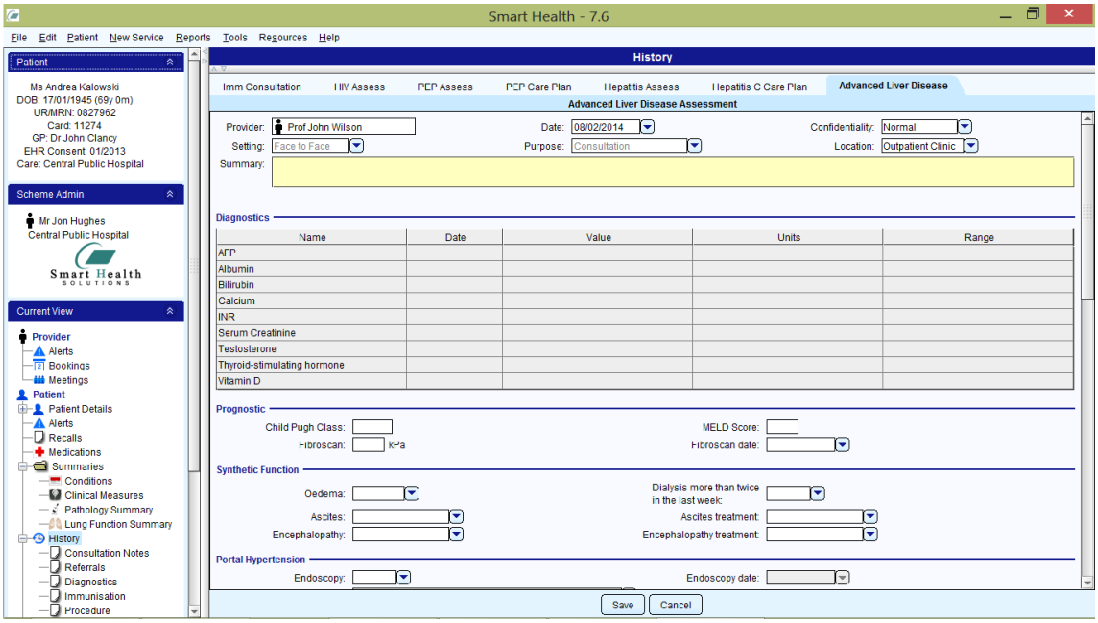


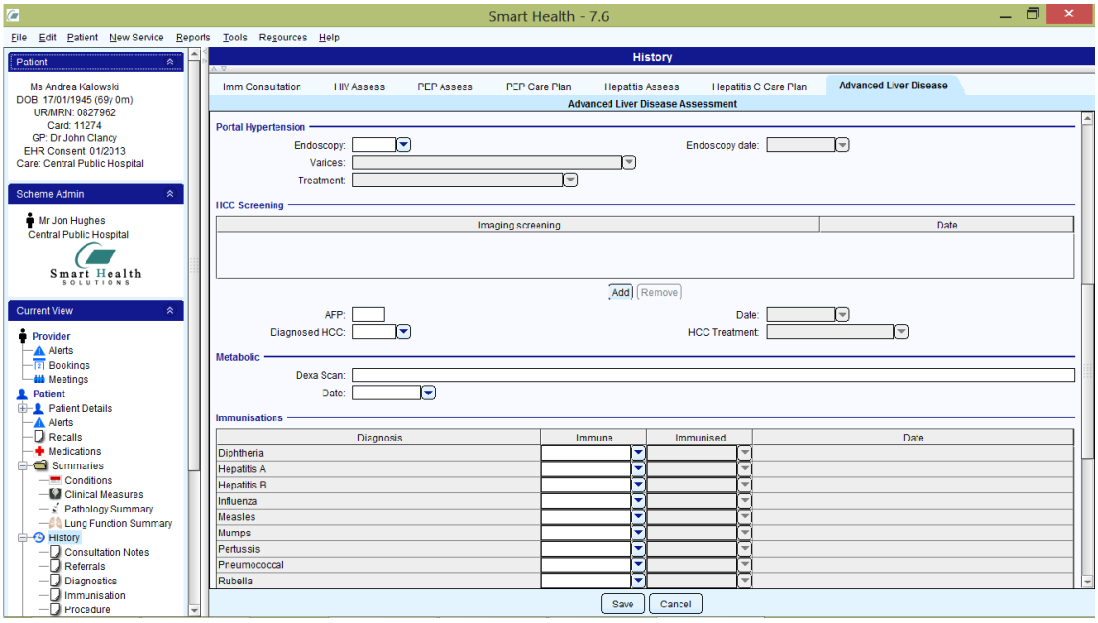


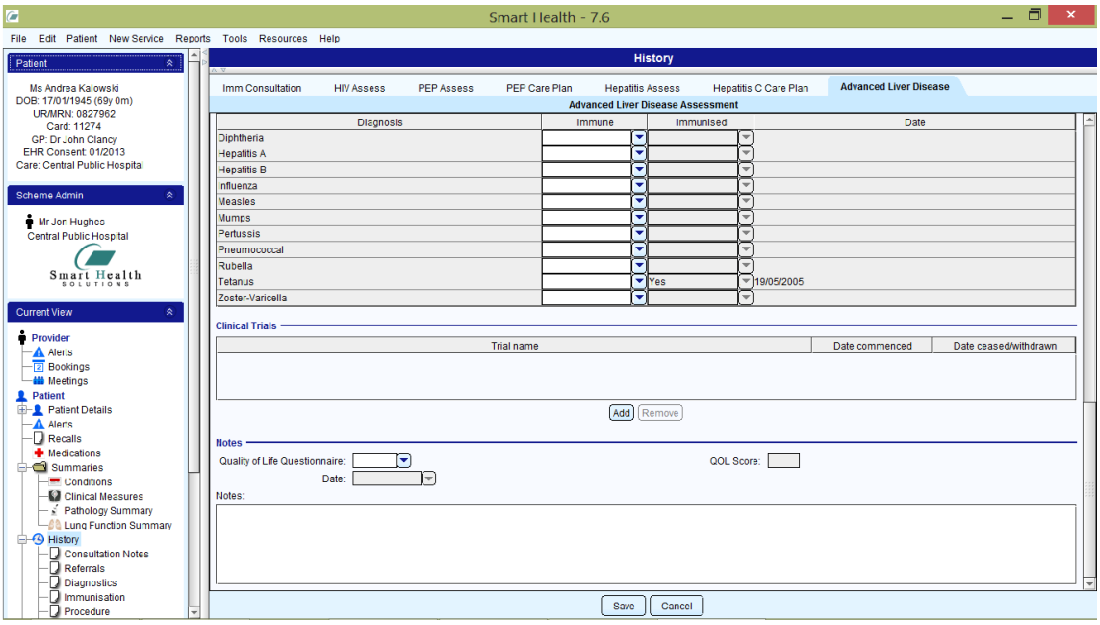
11.7.3.2 Hepatitis C Care Plan



11.7.3.3 Advanced Liver Disease Assessment







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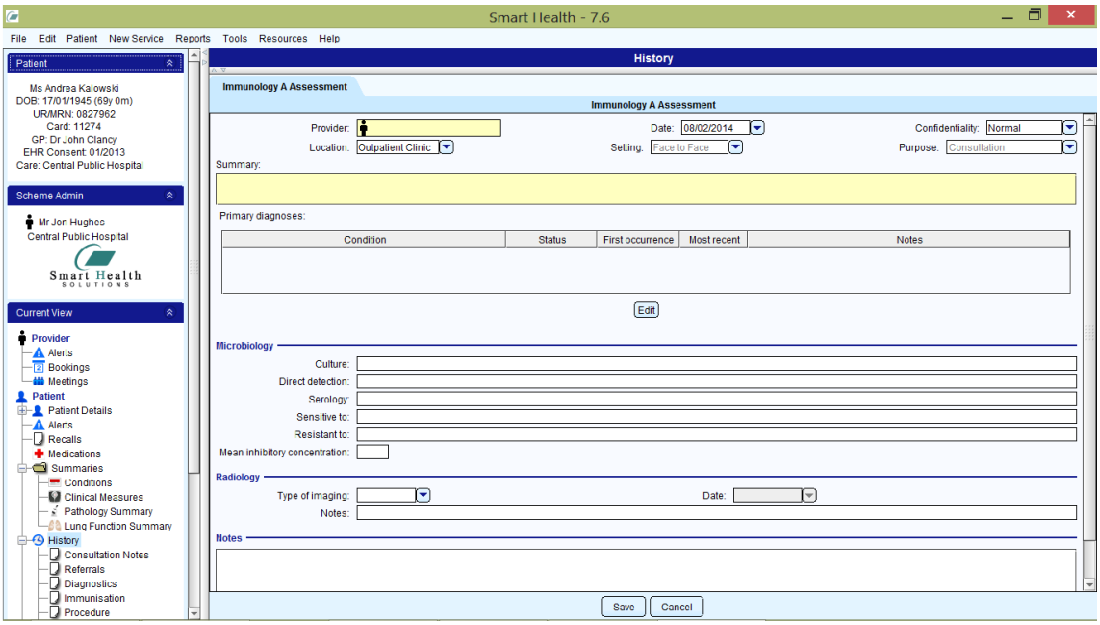
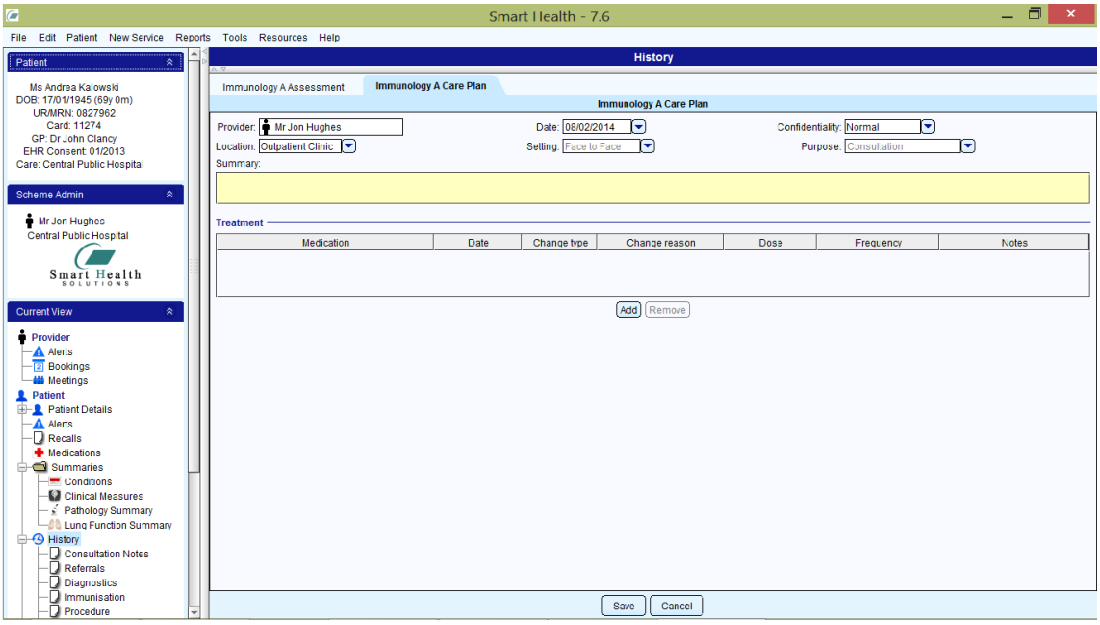
11.7.4 Immunology A

11.7.4.1 Immunology A Assessment

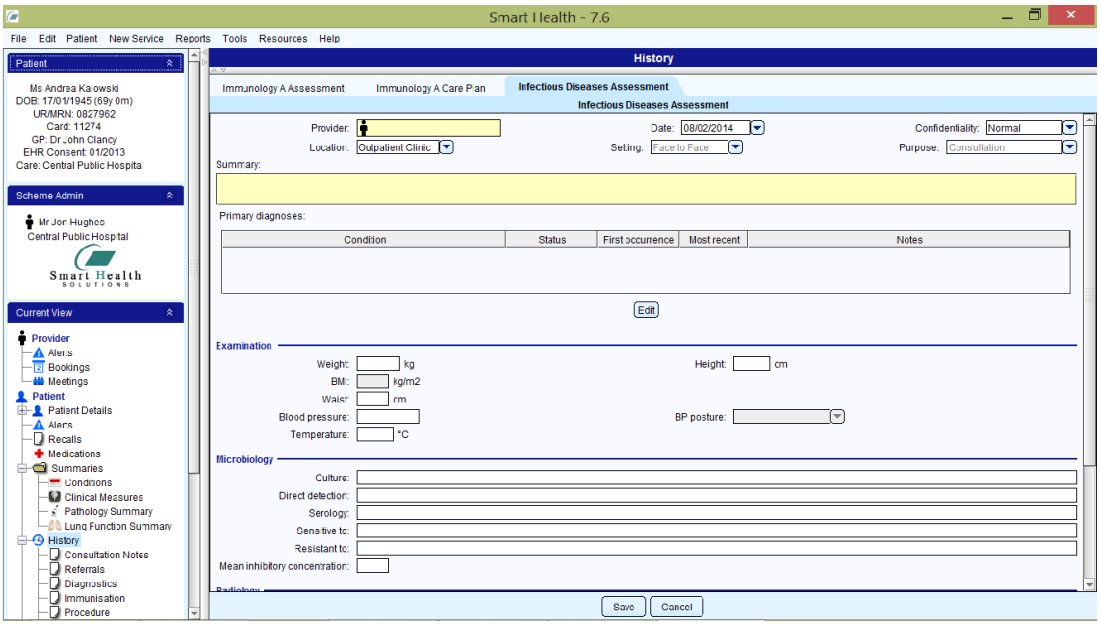


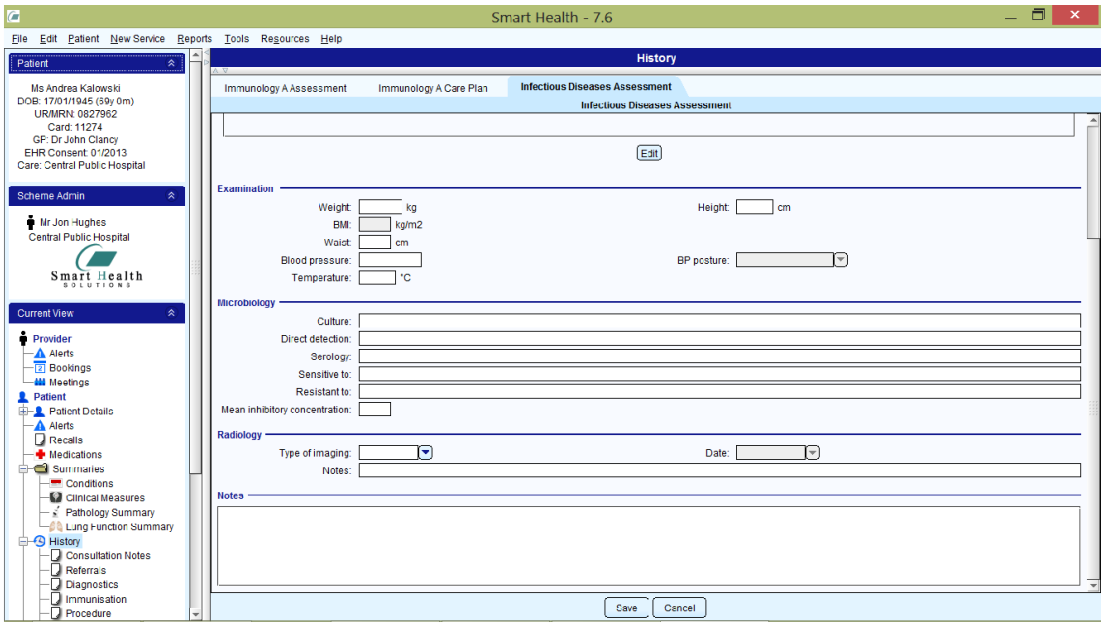
11.7.4.2 Immunology A Care Plan



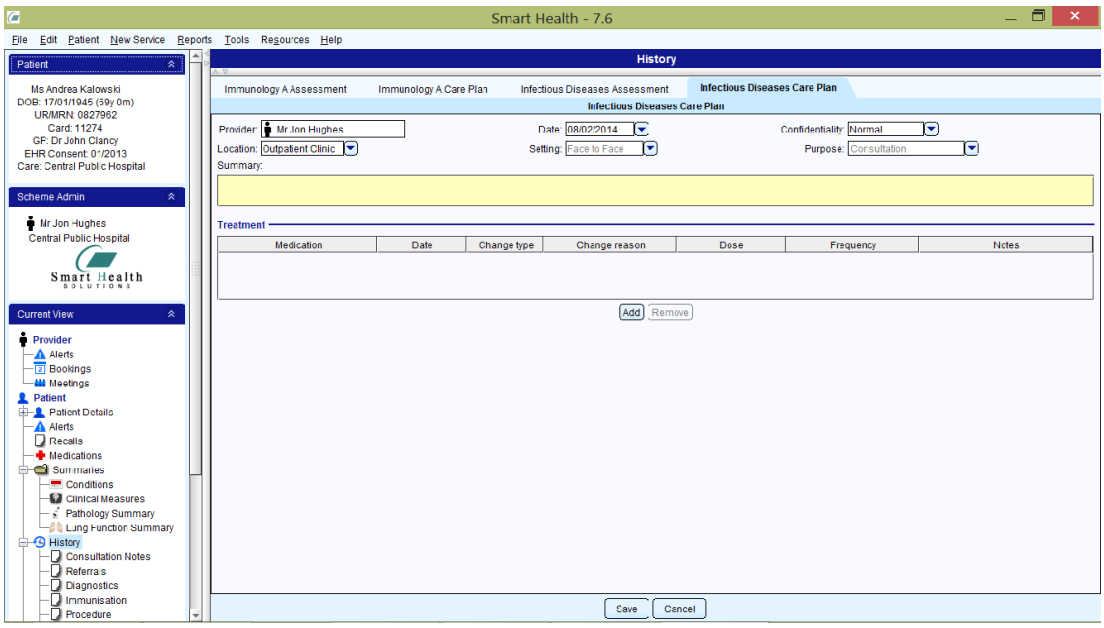
11.7.5 Infectious Diseases

11.7.5.1 Infectious Diseases Assessment



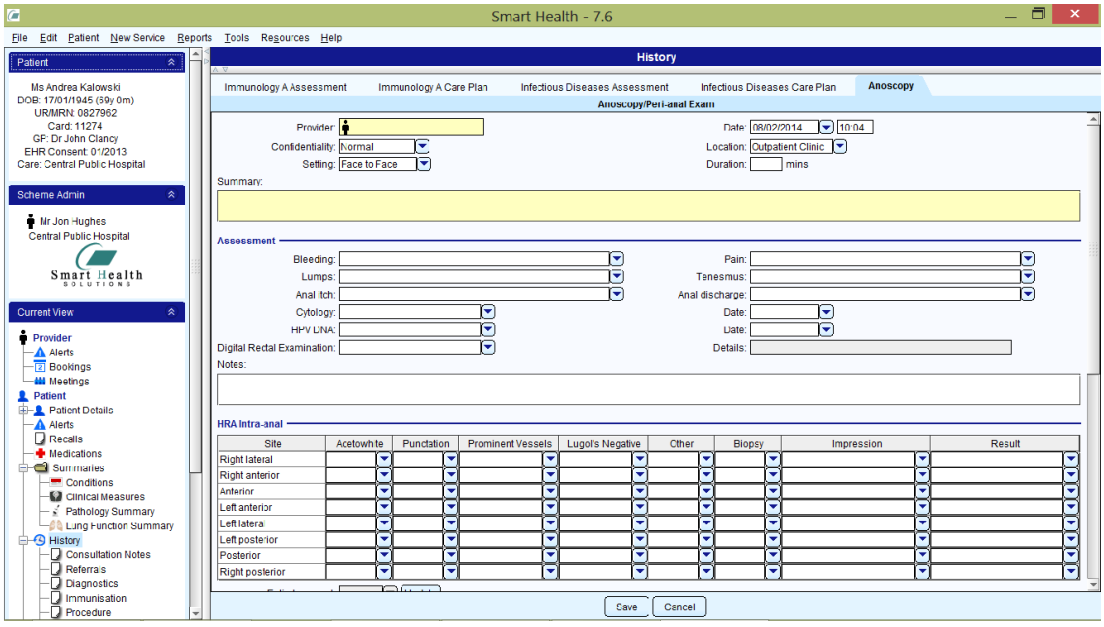


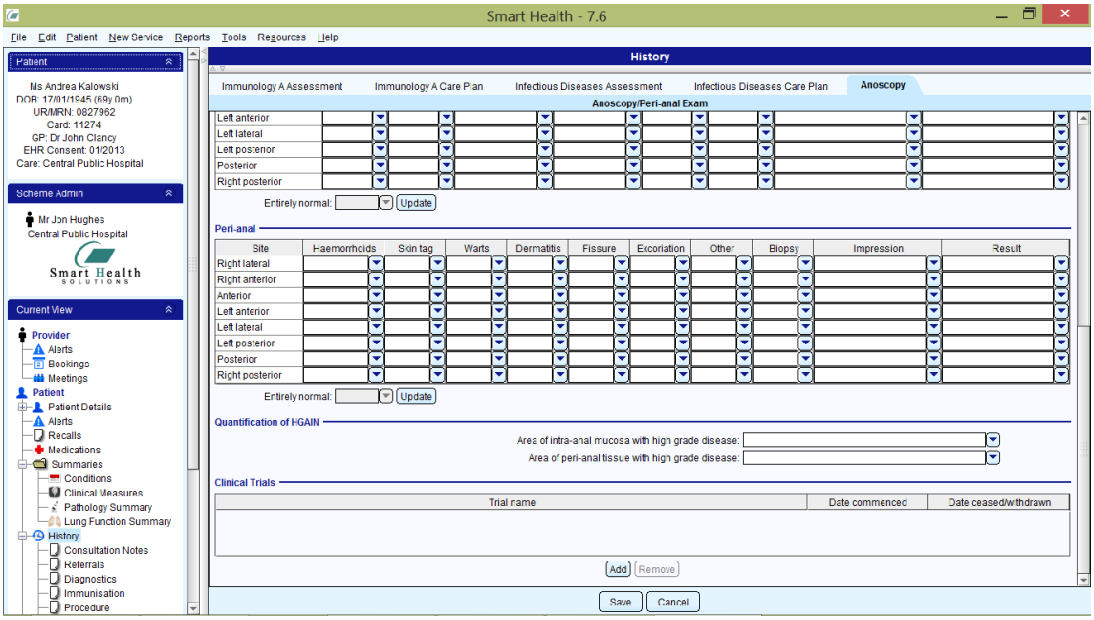
11.7.5.2 Infectious Diseases Care Plan



11.7.6 Anal Cancer

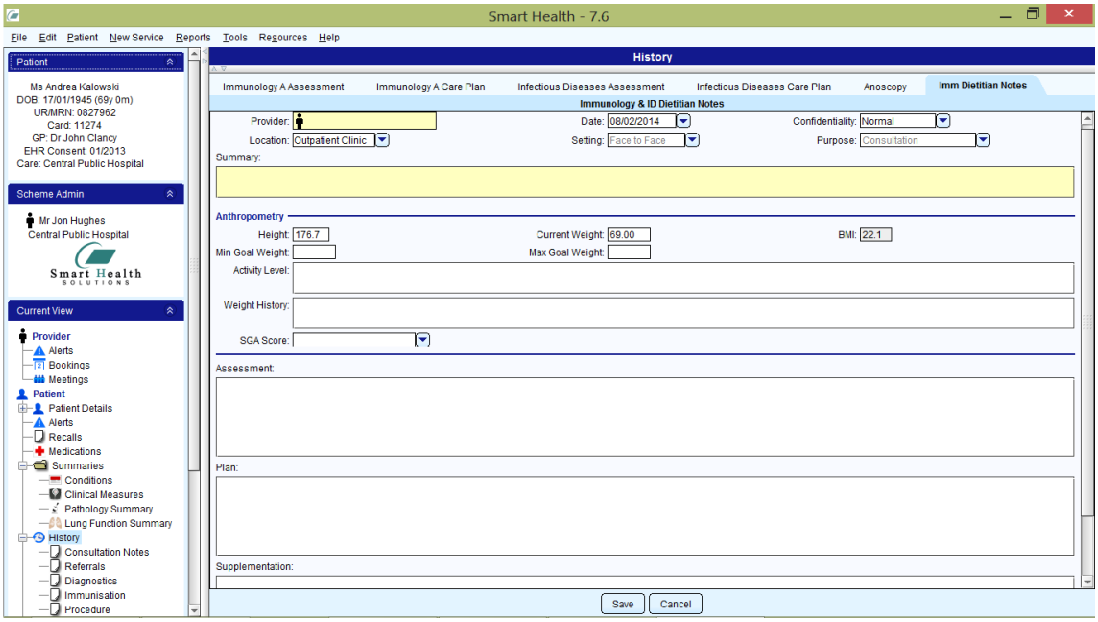
11.7.6.1 Anoscopy/Peri-anal Exam



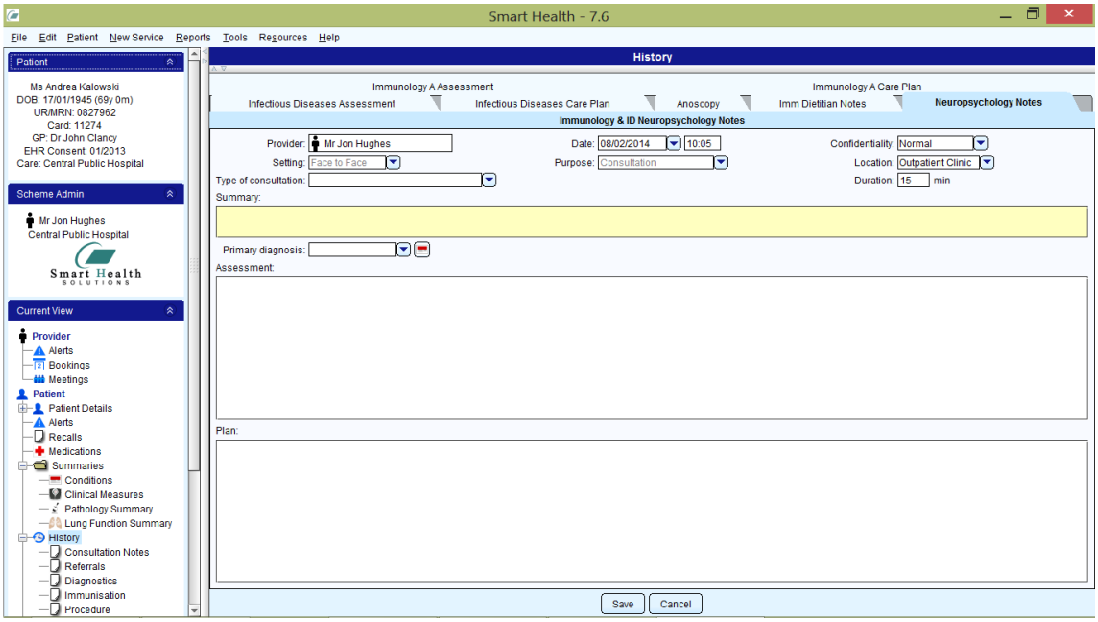


11.7.7 Allied Health

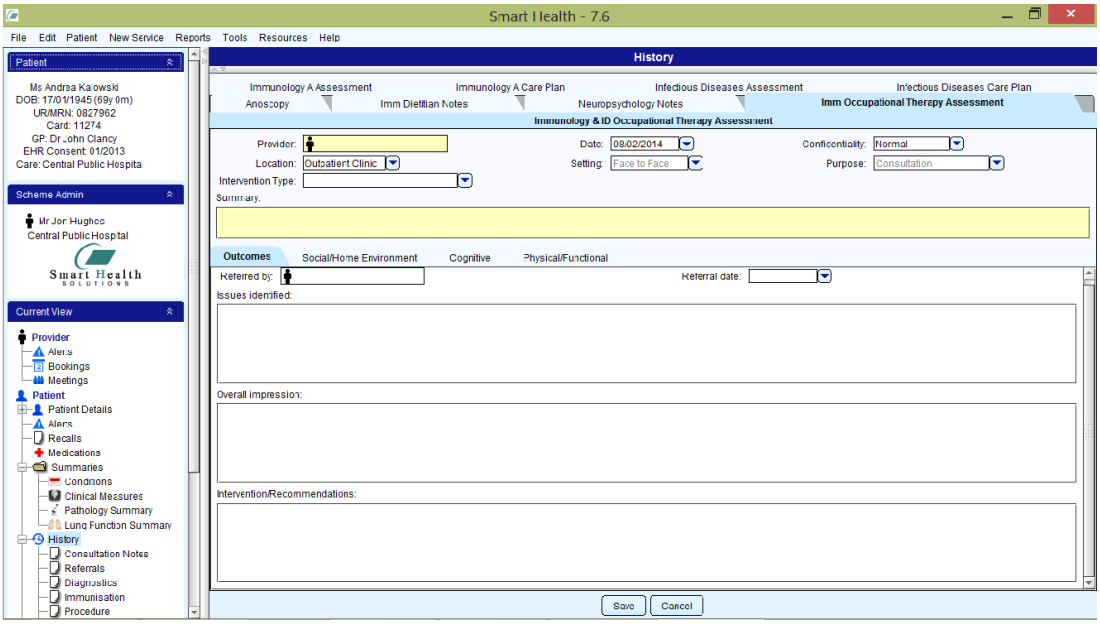
11.7.7.1 Dietitian Notes

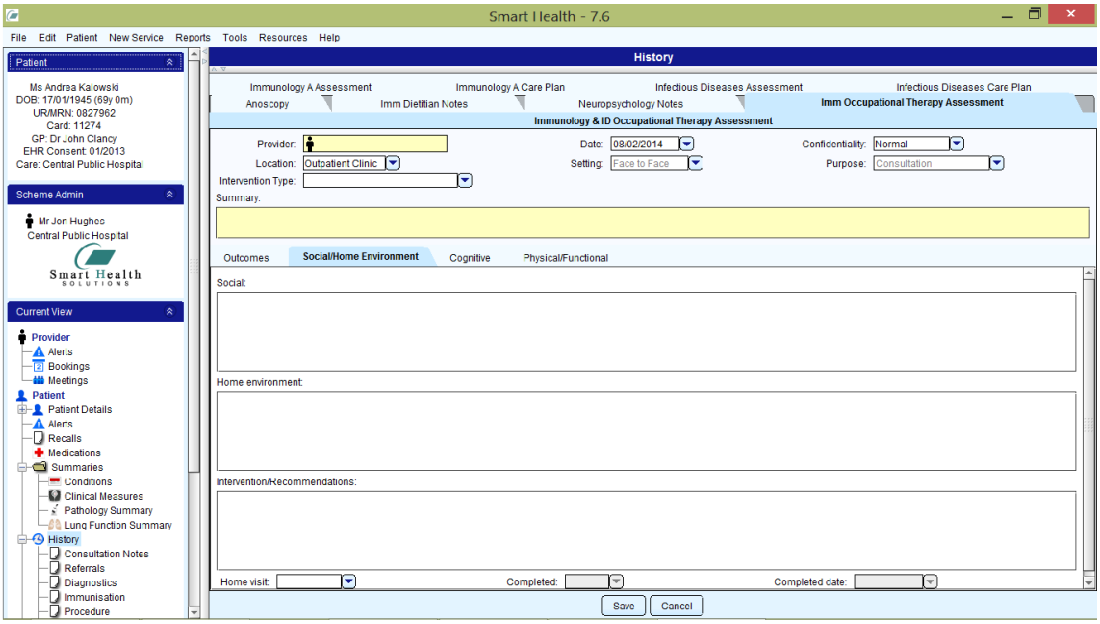


11.7.7.2 Neuropsychology Notes



11.7.7.3 Occupational Therapy Assessment

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Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
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Scheme Admin
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Immunology A Assessment
Immunology A Care Plan
Infectious Diseases Assessment
Infectious Diseases Care Plan
Anoscopy
Imm Dietitian Notes
Neuropsychology Notes
Imm Occupational Therapy Assessment
Immunology & ID Occupational Therapy Assessment
Provider:
Date: 08/02/2014
Confidentiality: Normal
Location: Outpatient Clinic
Setting: Face to Face
Purpose: Consultation
Intervention Type:
Summary:
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Social/Home Environment
Cognitive
Physical/Functional
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Home environment:
Intervention/Recommendations:
Home visit:
Completed:
Completed date:
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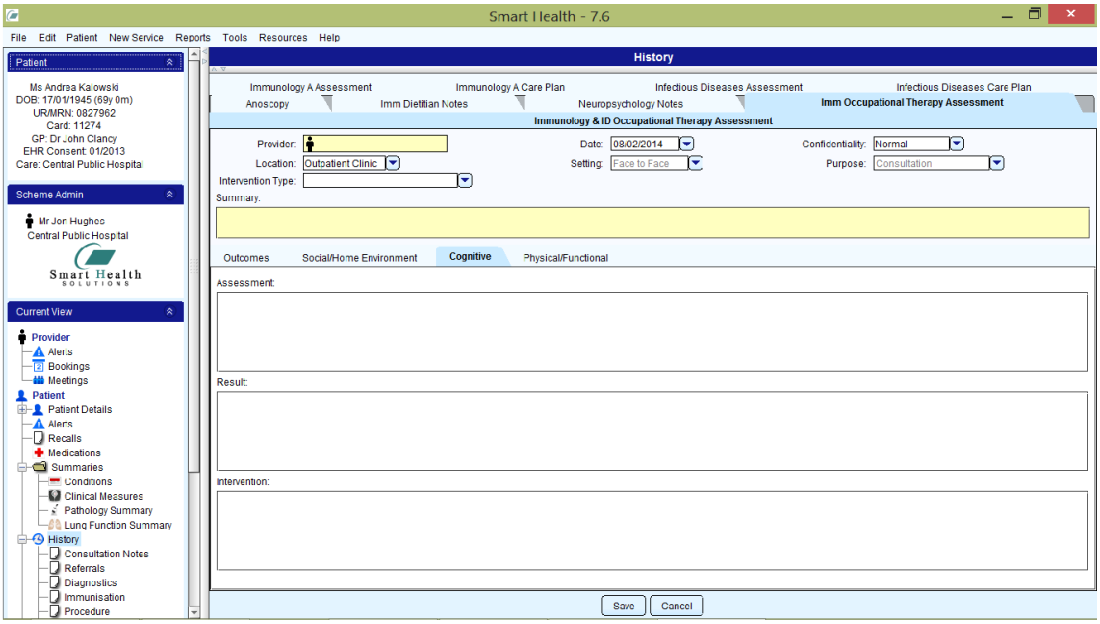
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Physical/Functional
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Result:
Intervention:
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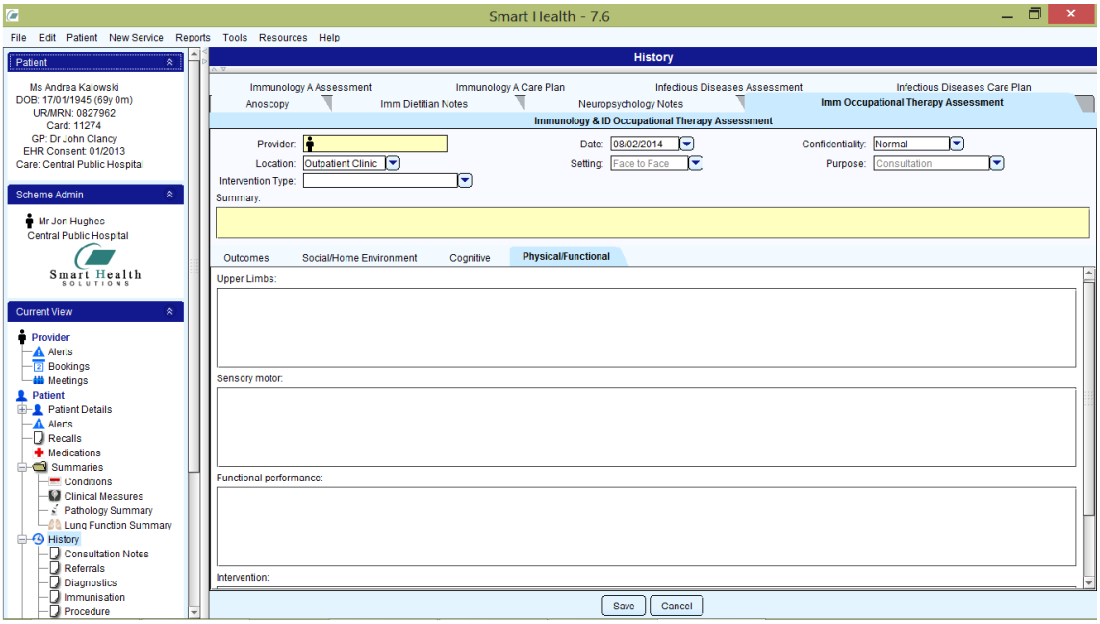
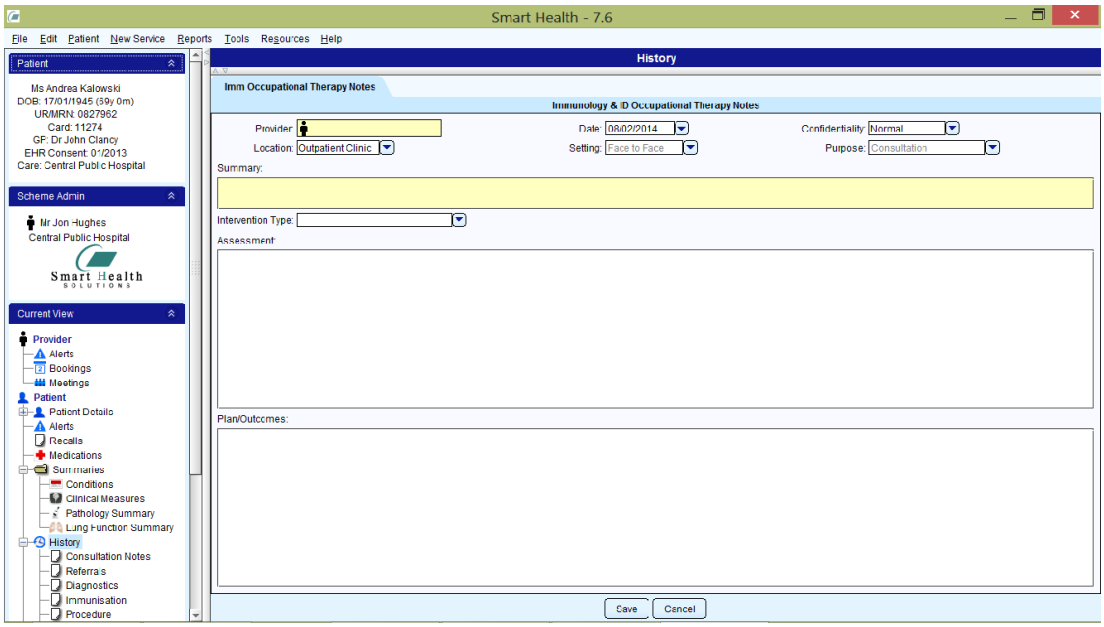
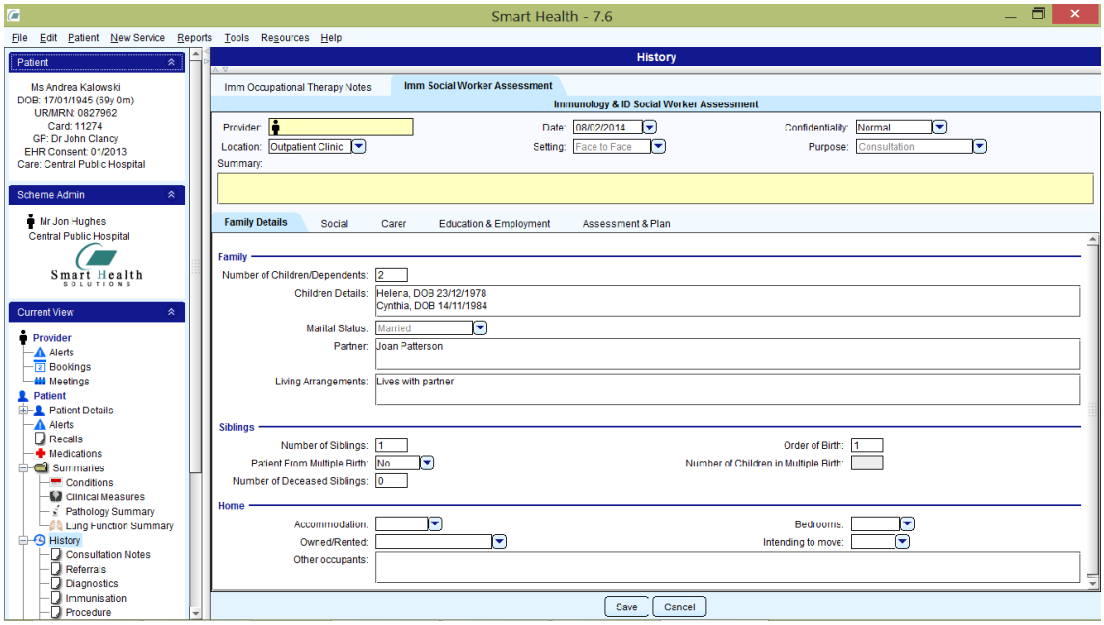
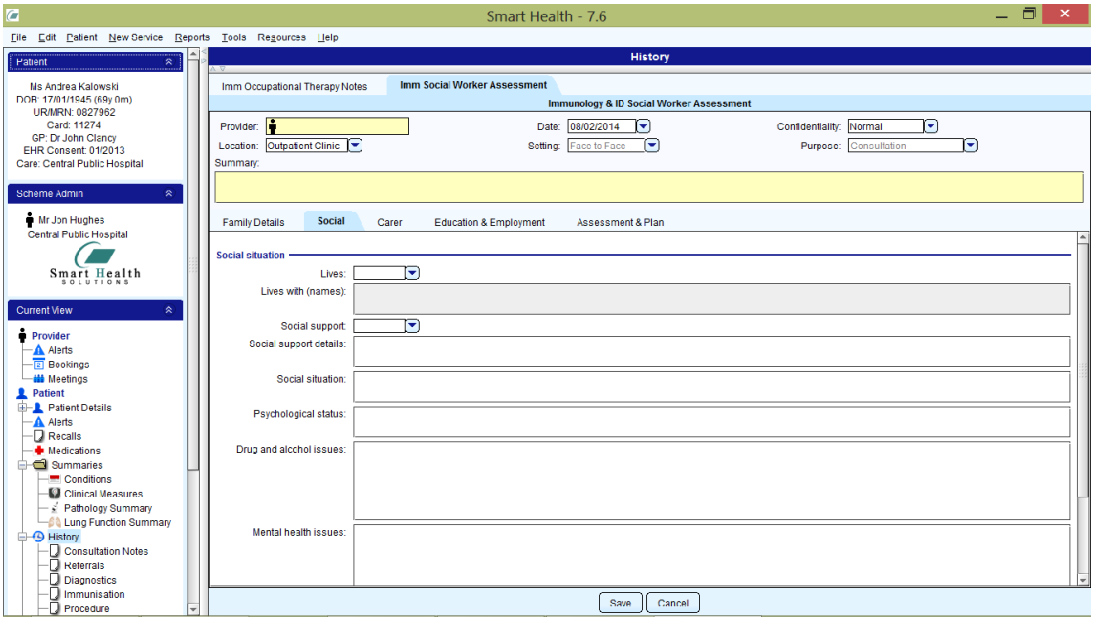


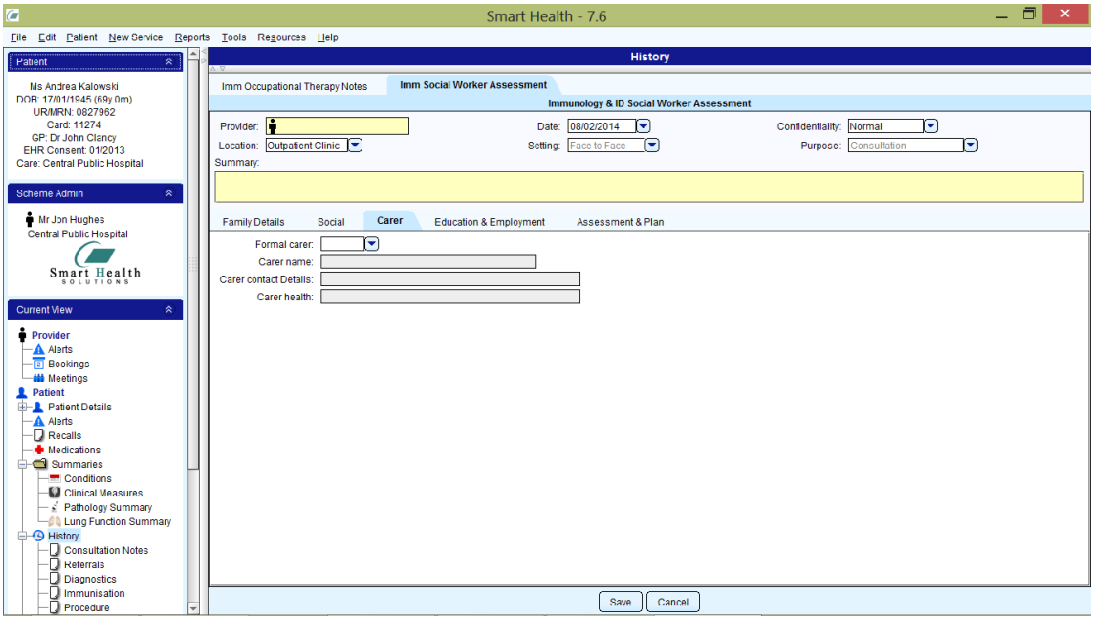
11.7.7.4 Occupational Therapy Notes



11.7.7.5 Social Worker Assessment



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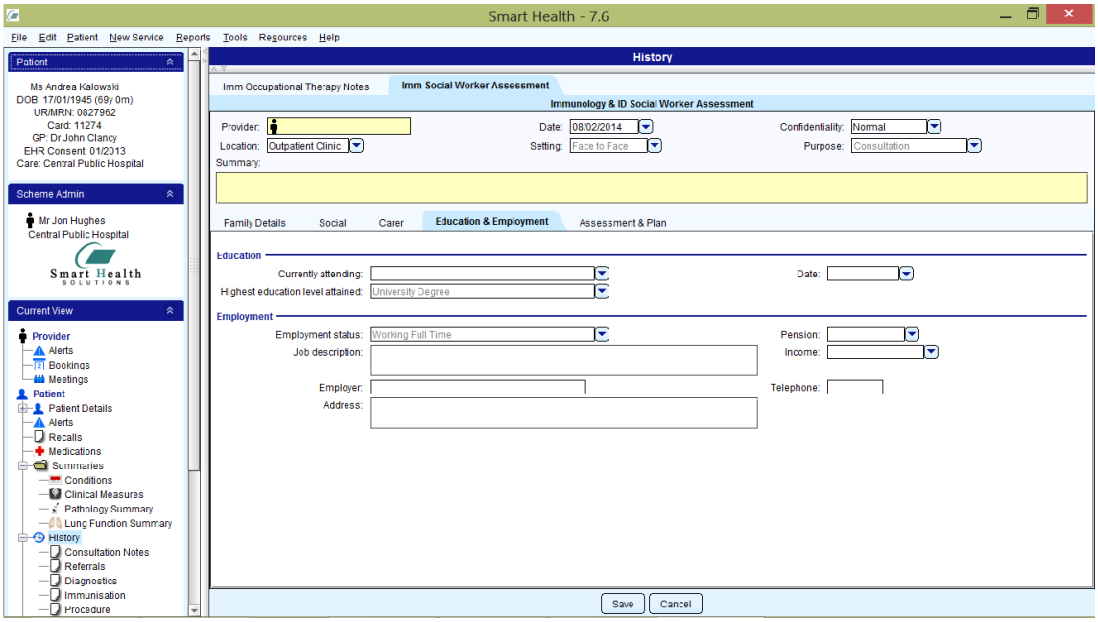
Imm Occupational Therapy Notes
Imm Social Worker Assessment
Immunology & ID Social Worker Assessment
Provider:
Date: 08/02/2014
Confidentiality: Normal
Location: Outpatient Clinic
Setting: Face to Face
Purpose: Consultation
Summary:
Family Details
Social
Carer
Education & Employment
Assessment & Plan
Formal carer:
Carer name:
Carer contact Details:
Carer health:
Save
Cancel


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 0827962
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
Care: Central Public Hospital
Scheme Admin
Mr Jon Hughes
Central Public Hospital
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Imm Occupational Therapy Notes
Imm Social Worker Assessment
Immunology & ID Social Worker Assessment
Provider:
Date: 08/02/2014
Confidentiality: Normal
Location: Outpatient Clinic
Setting: Face to Face
Purpose: Consultation
Summary:
Family Details
Social
Carer
Education & Employment
Assessment & Plan
Education
Currently attending:
Date:
Highest education level attained: University Degree
Employment
Employment status: Working Full Time
Pension:
Job description:
Income:
Employer:
Telephone:
Address:
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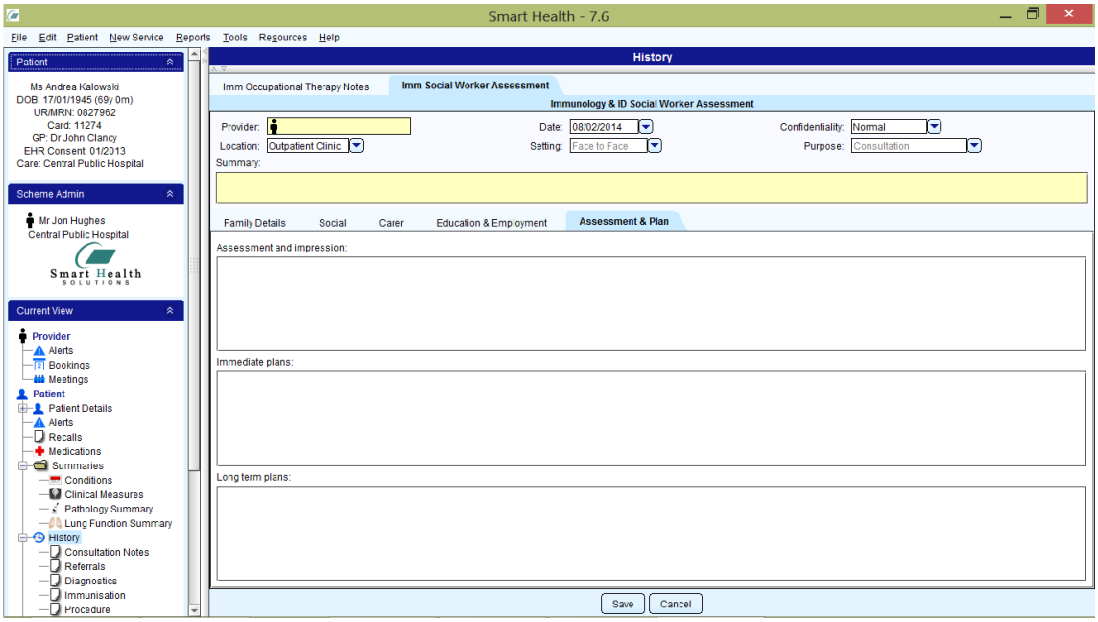
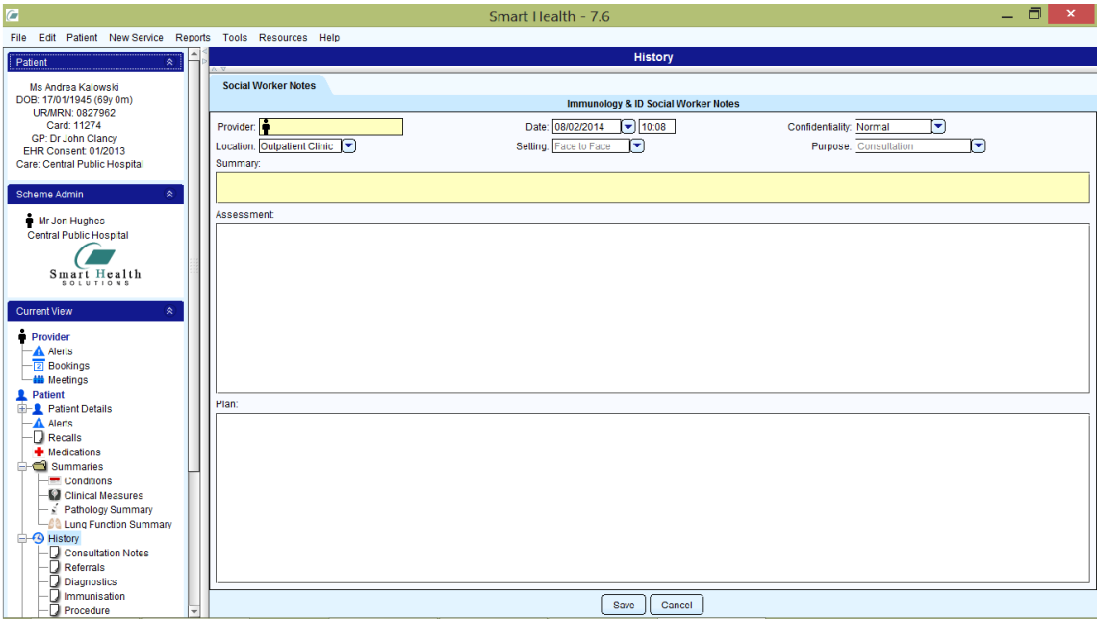
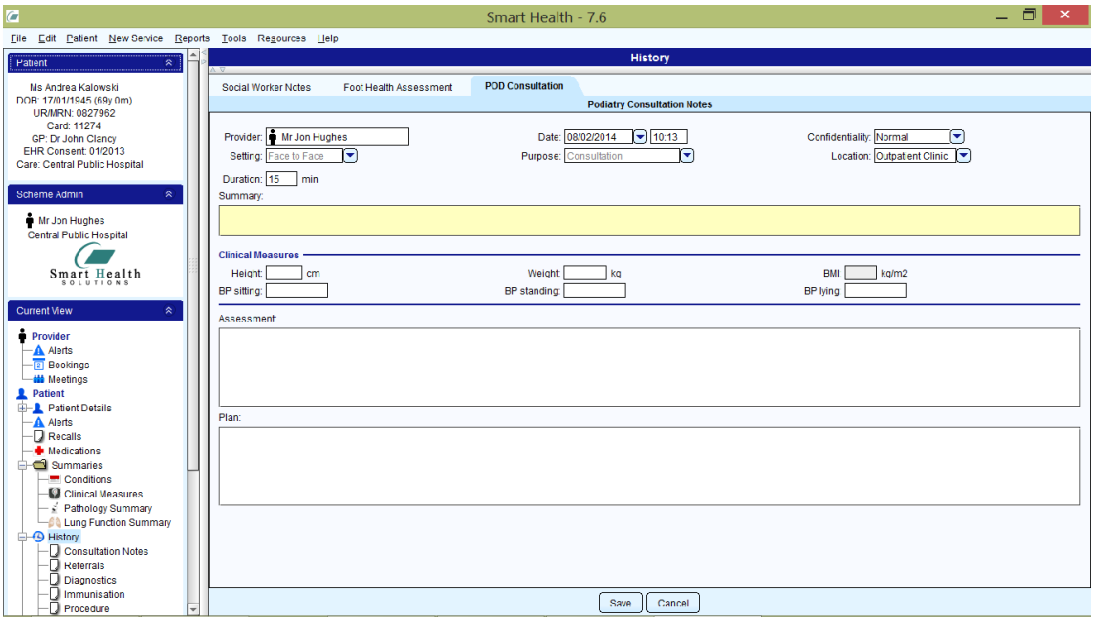


11.7.7.6 Social Worker Notes

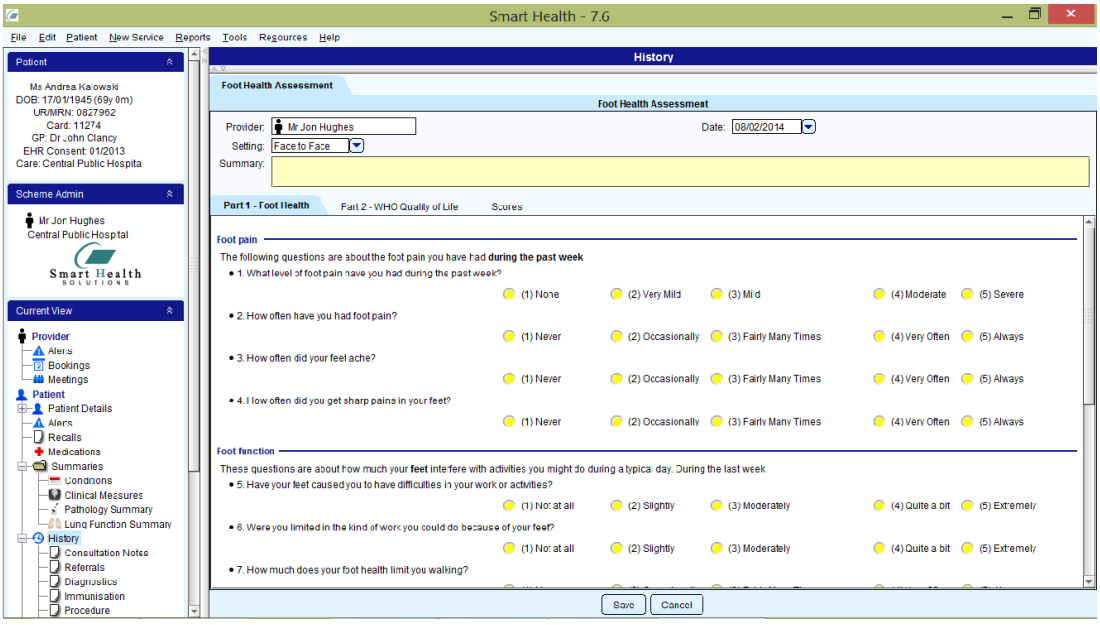


11.8 Podiatry

11.8.1 Consultation Notes



11.8.2 Foot Health Assessment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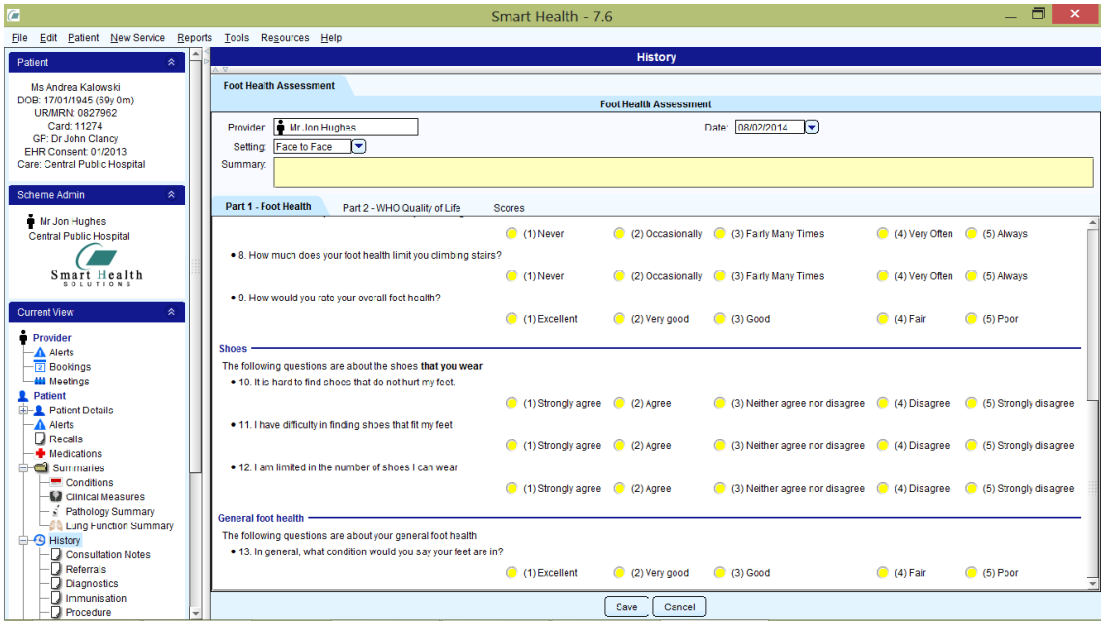
Provider: Mr Jon Hughes
Date: 08/02/2014
Setting: Face to Face
Summary:
Part 1 - Foot Health
Part 2 - WHO Quality of Life
Scores
Foot pain
The following questions are about the foot pain you have had during the past week
• 1. What level of foot pain have you had during the past week?
(1) None (2) Very Mild (3) Mild (4) Moderate (5) Severe
• 2. How often have you had foot pain?
(1) Never (2) Occasionally (3) Fairly Many Times (4) Very Often (5) Always
• 3. How often did your feet ache?
(1) Never (2) Occasionally (3) Fairly Many Times (4) Very Often (5) Always
• 4. How often did you get sharp pains in your feet?
(1) Never (2) Occasionally (3) Fairly Many Times (4) Very Often (5) Always
Foot function
These questions are about how much your feet interfere with activities you might do during a typical day. During the last week
• 5. Have your feet caused you to have difficulties in your work or activities?
(1) No: at all (2) Slightly (3) Moderately (4) Quite a bit (5) Extremely
• 6. Were you limited in the kind of work you could do because of your feet?
(1) No: at all (2) Slightly (3) Moderately (4) Quite a bit (5) Extremely
• 7. How much does your foot health limit you walking?
Save
Cancel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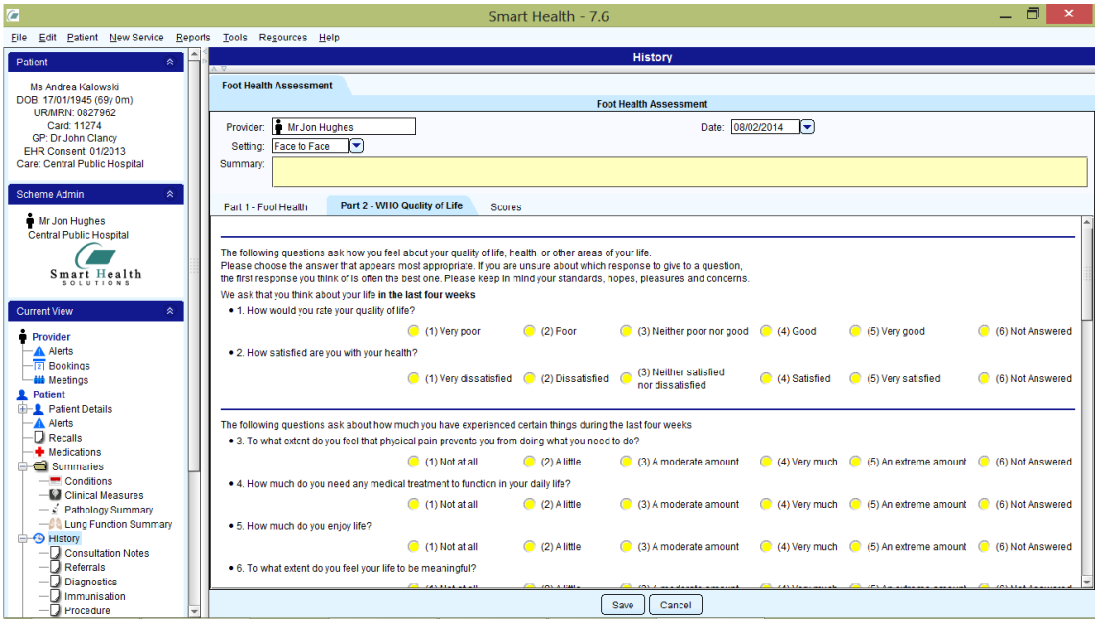
(1) Never (2) Occasionally (3) Fairly Many Times (4) Very Often (5) Always
• 8. How much does your foot health limit you climbing stairs?
(1) Never (2) Occasionally (3) Fairly Many Times (4) Very Often (5) Always
• 9. How would you rate your overall foot health?
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor
Shoes
The following questions are about the shoes that you wear
• 10. It is hard to find shoes that do not hurt my feet.
(1) Strongly agree (2) Agree (3) Neither agree nor disagree (4) Disagree (5) Strongly disagree
• 11. I have difficulty in finding shoes that fit my feet
(1) Strongly agree (2) Agree (3) Neither agree nor disagree (4) Disagree (5) Strongly disagree
• 12. I am limited in the number of shoes I can wear
(1) Strongly agree (2) Agree (3) Neither agree nor disagree (4) Disagree (5) Strongly disagree
General foot health
The following questions are about your general foot health
• 13. In general, what condition would you say your feet are in?
(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor
Save
Cancel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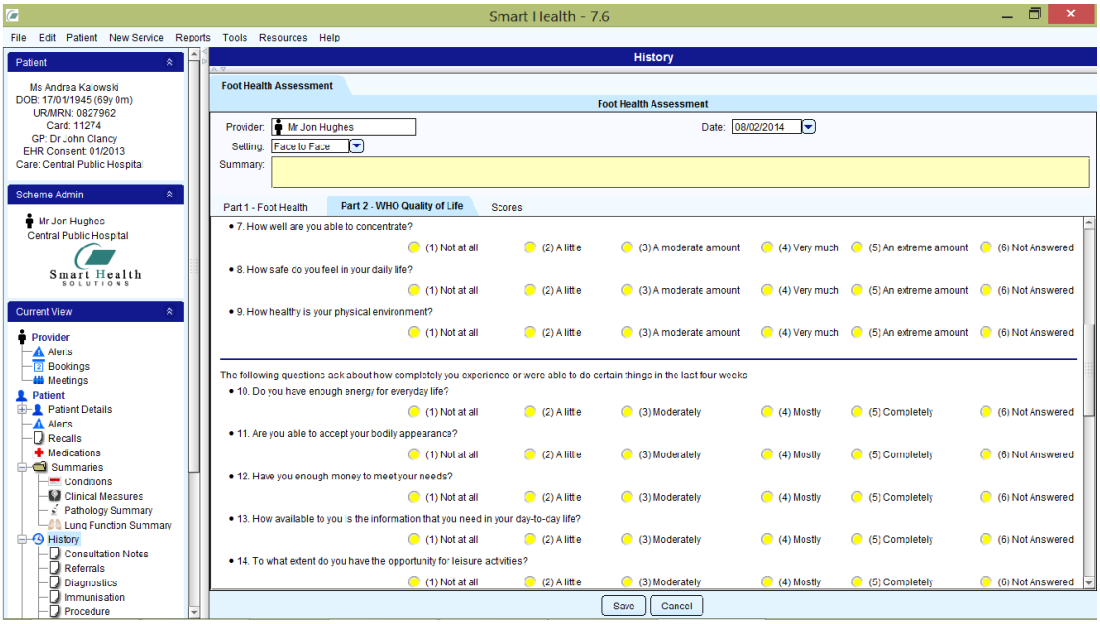
Part 1 - Foot Health
Part 2 - WHO Quality of Life
Scores
The following questions ask how you feel about your quality of life, health, or other areas of your life.
Please choose the answer that appears most appropriate. If you are unsure about which response to give to a question,
the first response you think of is often the best one. Please keep in mind your standards, hopes, pleasures and concerns.
We ask that you think about your life in the last four weeks
• 1. How would you rate your quality of life?
(1) Very poor (2) Poor (3) Neither poor nor good (4) Good (5) Very good (6) Not Answered
• 2. How satisfied are you with your health?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
The following questions ask about how much you have experienced certain things during the last four weeks
• 3. To what extent do you feel that physical pain prevents you from doing what you need to do?
(1) Not at all (2) A little (3) A moderate amount (4) Very much (5) An extreme amount (6) Not Answered
• 4. How much do you need any medical treatment to function in your daily life?
(1) Not at all (2) A little (3) A moderate amount (4) Very much (5) An extreme amount (6) Not Answered
• 5. How much do you enjoy life?
(1) Not at all (2) A little (3) A moderate amount (4) Very much (5) An extreme amount (6) Not Answered
• 6. To what extent do you feel your life to be meaningful?
Save
Cancel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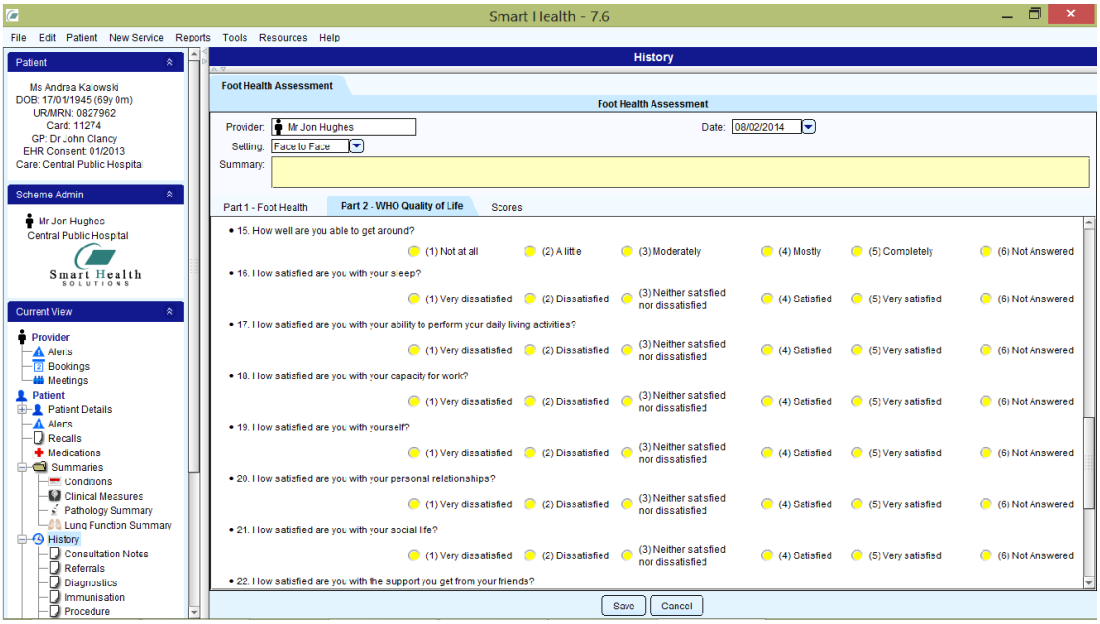
• 7. How well are you able to concentrate?
(1) Not at all (2) A little (3) A moderate amount (4) Very much (5) An extreme amount (6) Not Answered
• 8. How safe do you feel in your daily life?
(1) Not at all (2) A little (3) A moderate amount (4) Very much (5) An extreme amount (6) Not Answered
• 9. How healthy is your physical environment?
(1) Not at all (2) A little (3) A moderate amount (4) Very much (5) An extreme amount (6) Not Answered
The following questions ask about how completely you experience or were able to do certain things in the last four weeks
• 10. Do you have enough energy for everyday life?
(1) Not at all (2) A little (3) Moderately (4) Mostly (5) Completely (6) Not Answered
• 11. Are you able to accept your bodily appearance?
(1) Not at all (2) A little (3) Moderately (4) Mostly (5) Completely (6) Not Answered
• 12. Have you enough money to meet your needs?
(1) Not at all (2) A little (3) Moderately (4) Mostly (5) Completely (6) Not Answered
• 13. How available to you is the information that you need in your day-to-day life?
(1) Not at all (2) A little (3) Moderately (4) Mostly (5) Completely (6) Not Answered
• 14. To what extent do you have the opportunity for leisure activities?
(1) Not at all (2) A little (3) Moderately (4) Mostly (5) Completely (6) Not Answered
Save
Cancel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• 15. How well are you able to get around?
(1) Not at all (2) A little (3) Moderately (4) Mostly (5) Completely (6) Not Answered
• 16. How satisfied are you with your sleep?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 17. How satisfied are you with your ability to perform your daily living activities?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 18. How satisfied are you with your capacity for work?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 19. How satisfied are you with yourself?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 20. How satisfied are you with your personal relationships?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 21. How satisfied are you with your social life?
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 22. How satisfied are you with the support you get from your friends?
Save
Cancel

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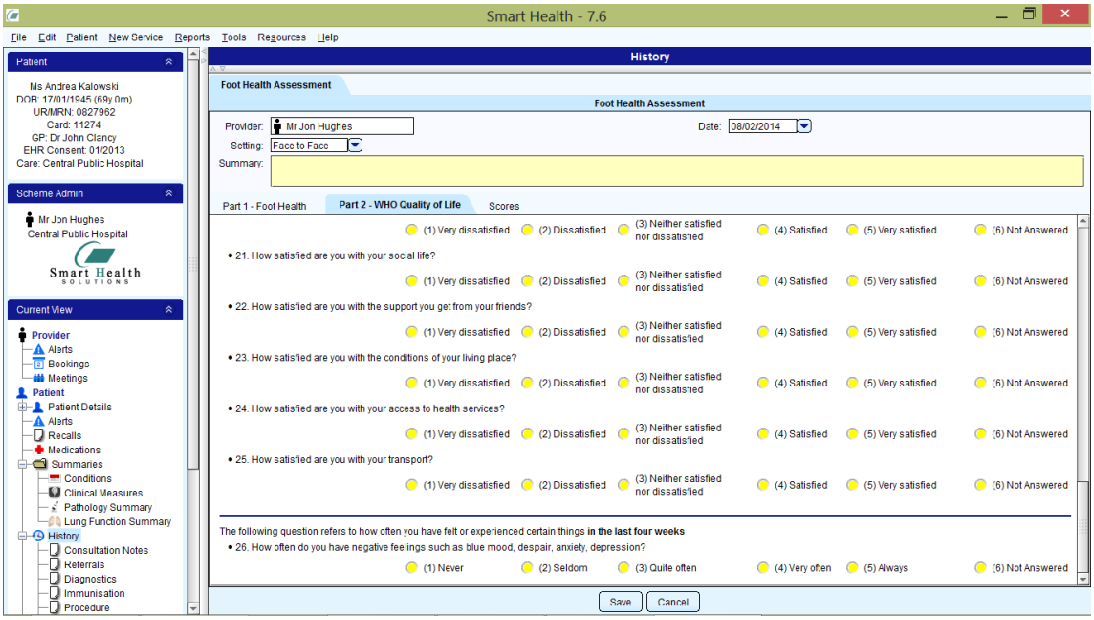
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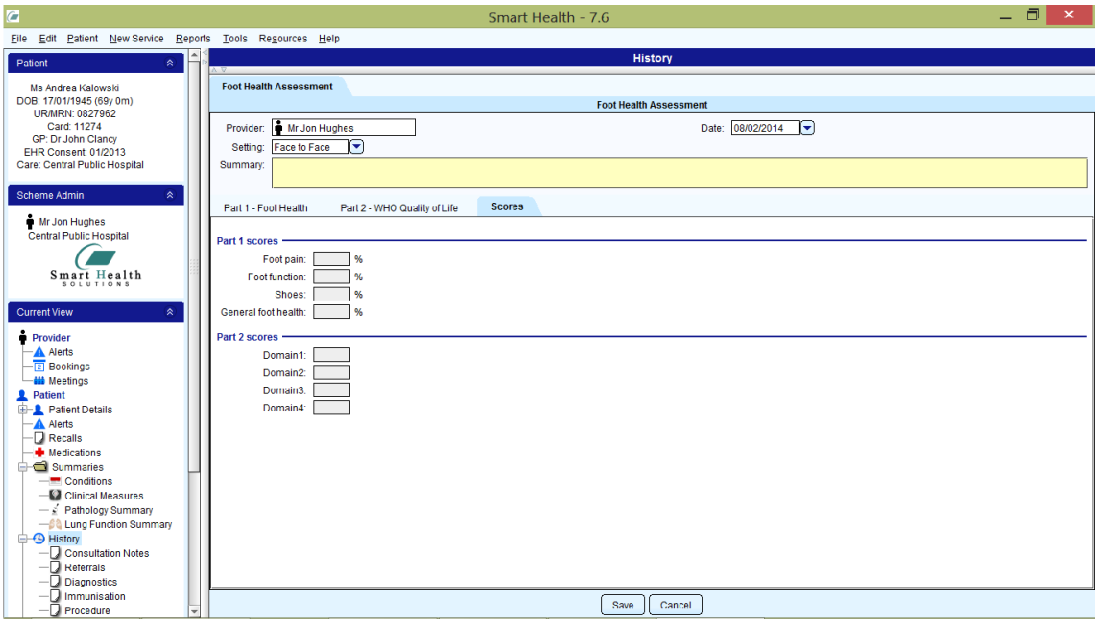
(1) Very dissatisfied (2) Dissatisfied (3) Neither satisfied nor dissatisfied (4) Satisfied (5) Very satisfied (6) Not Answered
• 21. How satisfied are you with your social life?
• 22. How satisfied are you with the support you get from your friends?
• 23. How satisfied are you with the conditions of your living place?
• 24. How satisfied are you with your access to health services?
• 25. How satisfied are you with your transport?
The following question refers to how often you have felt or experienced certain things in the last four weeks
• 26. How often do you have negative feelings such as blue mood, despair, anxiety, depression?
(1) Never (2) Seldom (3) Quite often (4) Very often (5) Always (6) Not Answered
Save
Cancel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Foot Health Assessment
Provider: Mr Jon Hughes
Date: 08/02/2014
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Summary:
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Part 2 - WHO Quality of Life
Scores
Part 1 scores
Foot pain: %
Foot function: %
Shoes: %
General foot health: %
Part 2 scores
Domain1:
Domain2:
Domain3:
Domain4:
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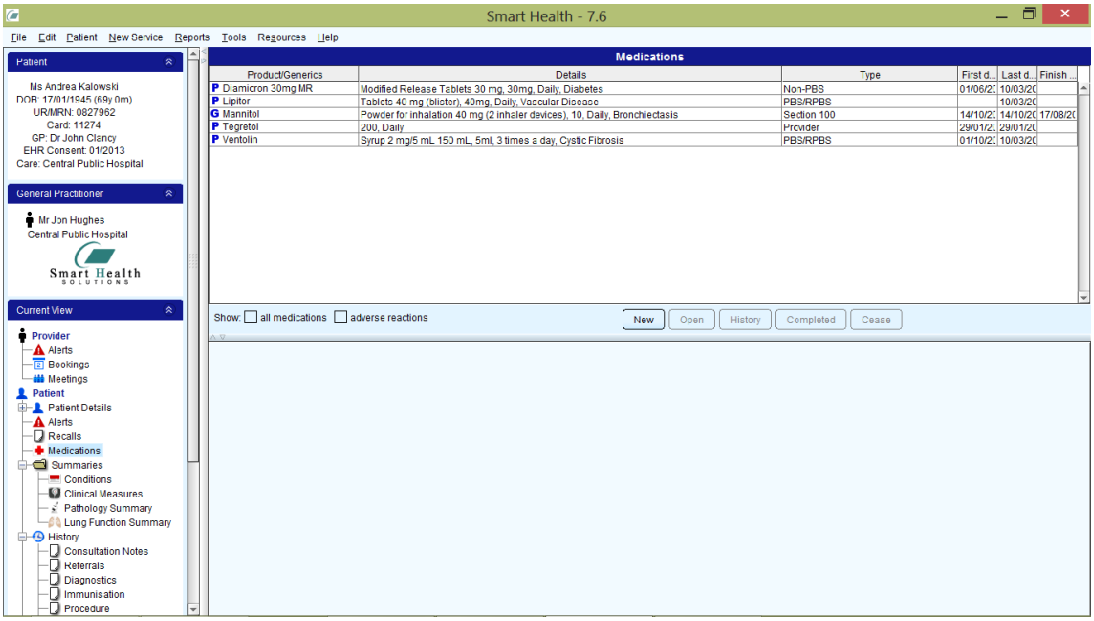
12. MEDICATIONS

The Medication summary was discussed in Section 9.4. The Medication summary allows users with the appropriate permissions to create medications, including prescriptions.

Smart Health includes full prescribing support, including MIMS drug information (formulations, packaging, recommended doses), full and abbreviated product information and consumer medicine information.



To create a new medication, click New, or select Medication from the New Service Menu.

To re-prescribe or record a medication, select the existing medication and click New. The medication form will automatically be populated with the details from the previous medication record.

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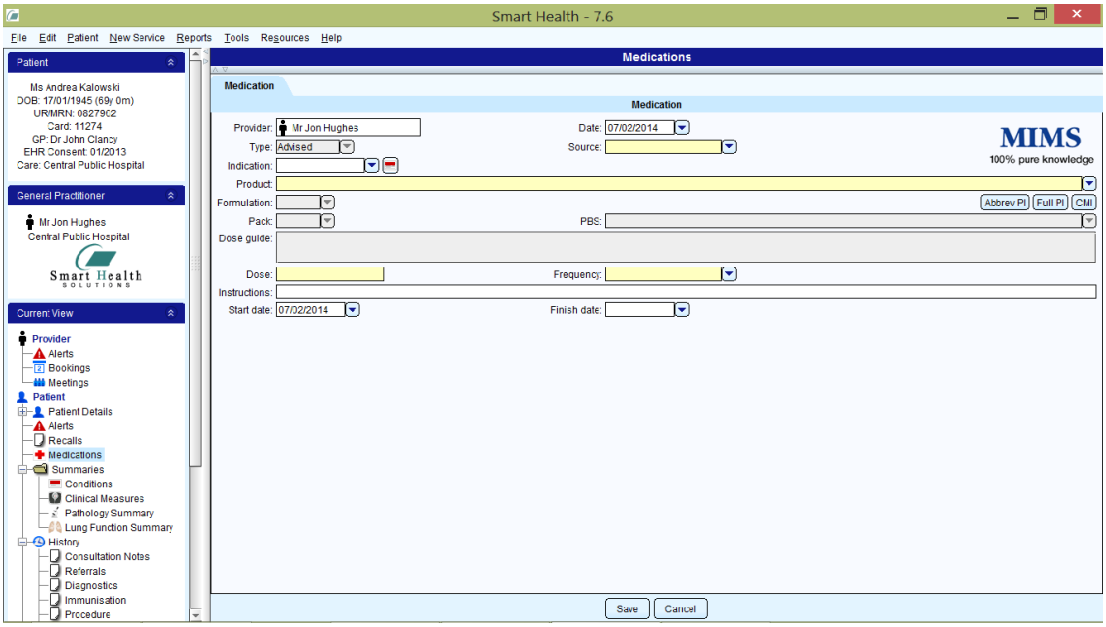
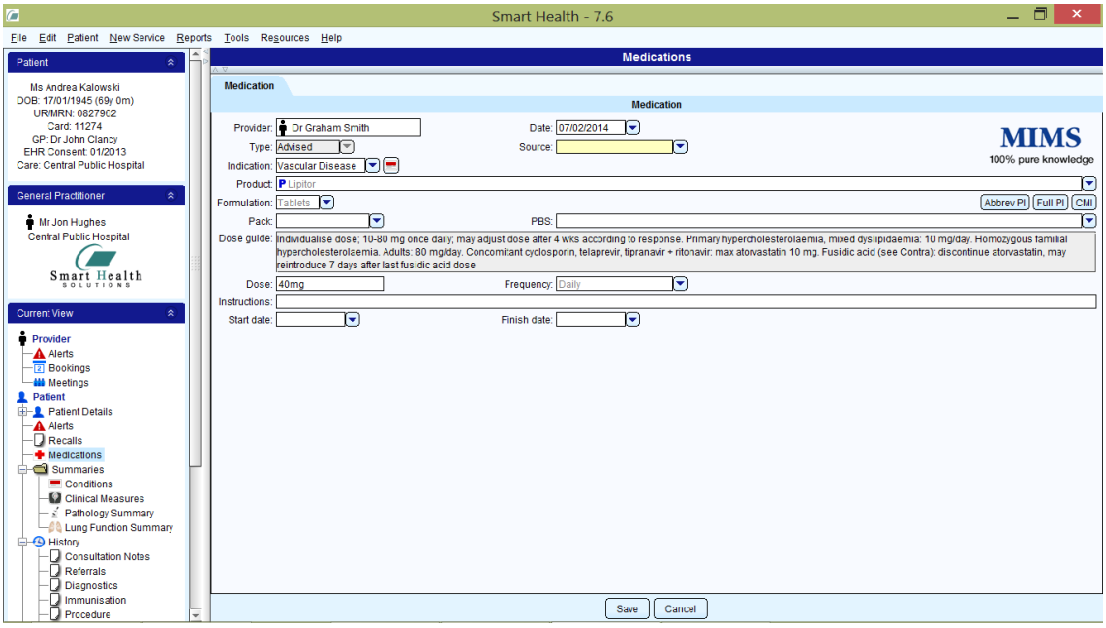
New medication:



Existing medication:



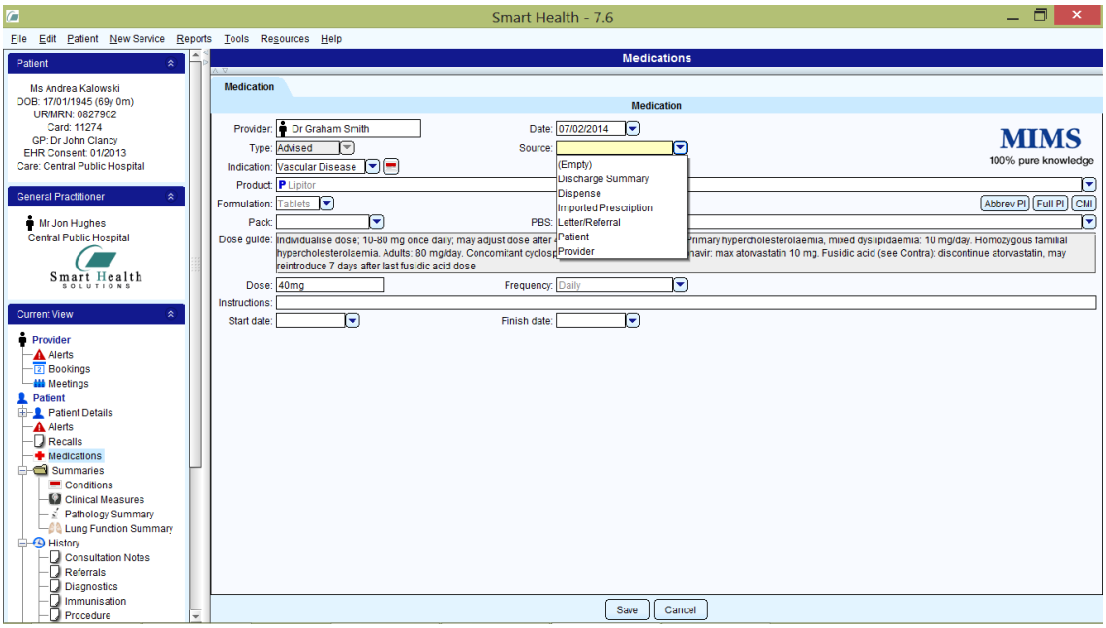
12.1 Prescription or Advised Medication

Select Prescribe to create a Prescription or Advised to record medication details from another source of information.

The user must have the Prescribe permission as well as provider and prescriber number to be able to prescribe medications. Provider and prescriber numbers can be added to a provider's record using Administration functions (Administration User Guide).

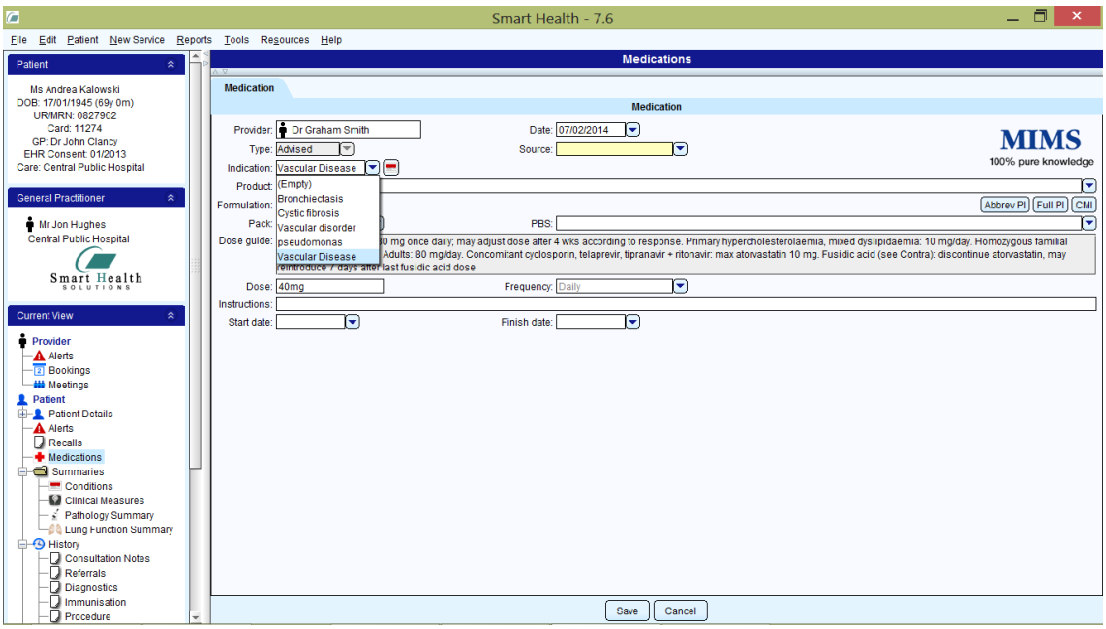
12.2 Source

If you selected Advised in the Prescription field, the Source field will allow you record the source of the medication information.



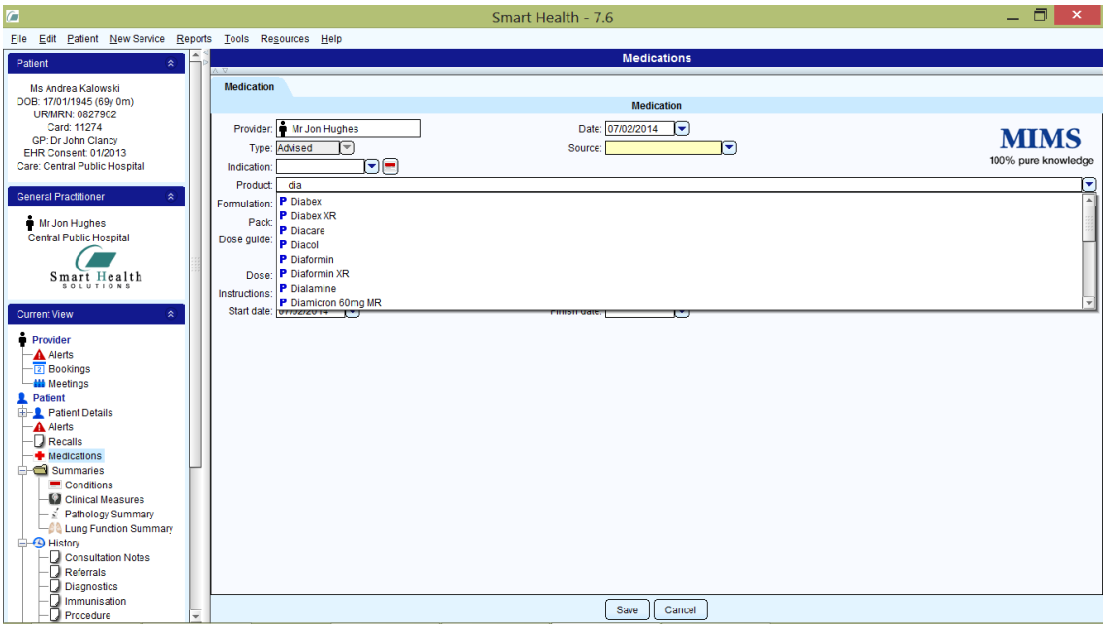
12.3 Indication

The Indication field lists the patient's known conditions. If you wish to enter a new condition (for which a medication will be prescribed or recorded), click Conditions/Diagnoses (under Patient Details) to update the Problem List. The new diagnosis will then appear in the list of Indications in the Medication form.

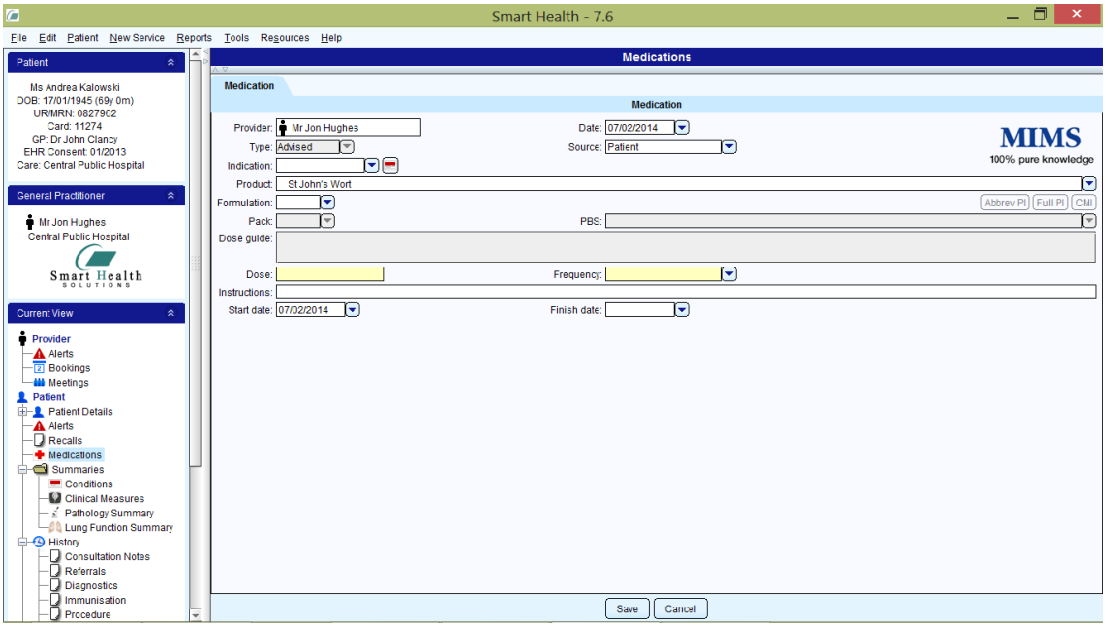


12.4 Product

Type two or more letters of a drug name to display a list of drugs with matching names.



If you have selected an Advised medication and you type in a non-MIMS drug name, you can save it as a non-MIMS medication (however, other fields in the medication/prescription record may be disabled):



12.5 Product Information

Once you have selected a Product, you can click the Abbrev PI or Full PI buttons to display brief or full product information pages respectively.

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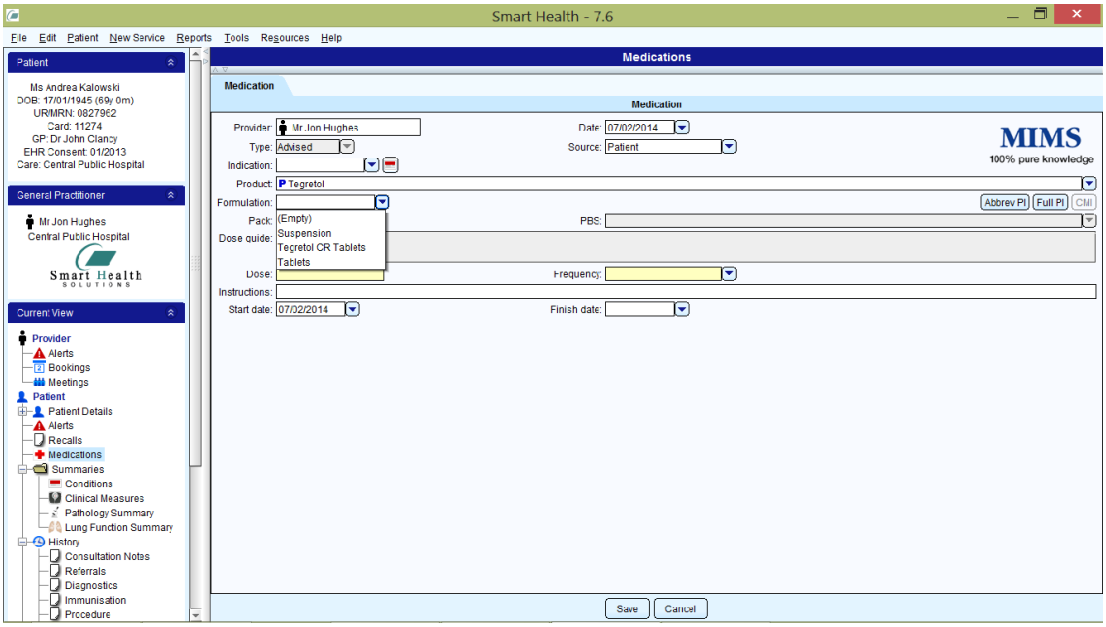
MIMS Pharmaceutical Information System - Mozilla Firefox
Smart Health
Next Generation Healthcare
Tegretol
MIMS Abbreviated Prescribing Information
MIMS
100% pure knowledge
Tegretol
Generic Ingredients: carbamazepine
Company Novartis Pharmaceuticals Australia Pty Ltd
Pregnancy Category D
Permitted in sport
Use: Anticonvulsant, neuroleptic, psychotropic dibenzazepine derivative. Treatment of partial seizures (+/- sec generalisation), generalised seizures with tonic clonic component, mixed seizure patterns (alone, combination therapy), trigeminal neuralgia (idiopathic or MS induced), idiopathic glossopharyngeal neuralgia, treatment of mania, maintenance treatment of bipolar affective disorders
Contra: Hypersensitivity to structurally related drugs eg TCAs; A-V block; SI D; hepatic porphyria, bone marrow depression history; MAOIs (within 14 days); hepatic failure
Prec: Not for status epilepticus, trivial facial pain, headache, mixed seizure disorder (incl atonic, myoclonic, absence); cardiac, hepatic, renal impairment history, monitor FBC, LFTs, BUN, urinalysis, ophthalmology, emergence, worsening of depression, suicidality, unusual mood/ behaviour change; renal conditions associated with low Na (monitor serum Na at baseline, 2 wks, then mthly for 3 mths); thyroid replacement therapy (monitor thyroid function); previous haematological drug reaction; interrupted therapy; incr IOP, prostatism, urinary retention (monitor); latent psychosis; abrupt dose reduction, withdrawal; cross sensitivity (oxcarbazepine, phenytoin), human leucocyte antigen (HLA) B*1502 allele +ve (higher prevalence in Asian race, predisposes to severe skin reaction, see full PI), HLA A*3101 allele (Japanese, Caucasian, indigenous Americans, Hispanic, southern Indian, Arabic, predisposes to hypersensitivity syndrome incl maculopapular rash), consider pretreatment genetic screening, monitor plasma concentration in certain cases eg absorption disorder (see full PI), hereditary fructose intolerance (susp); elderly, women of childbearing age (consider nonhormonal contraception); pregnancy (commence folic acid supplements 4 wks prior to conception, continue for 12 wks postconception, admin vit K during last wks of pregnancy and to newborn); lactation; children < 6 yrs
Adverse: CNS (eg dizziness, ataxia, somnolence, fatigue, headache, diplopia), endocrine (eg oedema, hyponatraemia), hepatic disturbance; blurred vision; GI upset; blood dyscrasia; urticaria, allergic dermatitis; hypersensitivity incl hepatic (eg vanishing bile duct syndrome), DRESS, multi-organ (withdrew); very rare: porphyria, severe skin reaction, NMS, aseptic meningitis, lens opacity, conjunctivitis, renal disorder; others (complex), see full PI
Interact: See Contra; CYP3A4 inhibitors (incl azole antifungals (eg itraconazole, voriconazole), macrolides, HIV protease inhibitors, loratadine, terfinadine, grapefruit juice), inducers (incl other anticonvulsants, St John's wort), substrates (incl OCs, warfarin, digoxin, corticosteroids, buprenorphine, mefloquine, paracetamol, tramadol, theophylline), Ca channel blockers, HMG-CoA reductase inhibitors, ivabradine, some antidepressants, Li, dextropropoxyphene; ibuprofen; quetiapine; danazol; valproic acid; velnacrine; valpromide; primidone; doxycycline; nifedipine; olanzapine; acetazolamide; nicotinamide; ticlopidine; cisplatin; doxorubicin; rifampicin; isotretinoin; aripiprazole; praziquantel; albendazole; abarelix; metoclopramide; drugs lowering Na (eg diuretics, drugs assoc with inappropriate ADH secretion); alcohol; ischaric; levetiracetam; imatinib; cyclophosphamide; lapatinib; temsirolimus; tadalafil; immunosuppressants incl cyclosporin; levothyroxine; poss: cimetidine, omeprazole; lab tests: false +ve perphenazine (HPLC), TCA (fluorescence polarised immunoassay); others (complex), see full PI
Tegretol Tablets Rx (S4)
Carbamazepine; white scored; gluten free
Pack 100 mg [100]
Pack 100 mg [100] x 2 (G) PBS/RPBS (NP) (Rp 2) PBS: $21.87 Brand Price Premium: $2.98
Pack 200 mg [100]
Pack 200 mg [100] x 2 (G) PBS/RPBS (NP) (Rp 2) PBS: $32.17 Brand Price Premium: $2.96
Dose Should be taken with food. Epilepsy, Incr dose gradually until optimal seizure control, then maintain at lowest effective dose. Adults, children > 15 yrs: initially 100-200 mg 1-2 times daily; may incr to 400 mg 2-3 times daily; rarely 2000 mg/day. Children less than or equal to 5 yrs: initially 20-60 mg/day, may incr by less than or equal to 60 mg/day every 3-7 days to 600 mg/day; 6-12 yrs: initially 100 mg/day in 2 divided doses, may incr by 100 mg/day in 3-4 divided doses at wkly intervals to 1000 mg/day; 13-15 yrs: initially as for adults. Maintenance: Children 6-10 yrs: 400-600 mg/day; 11-15 yrs: 600-1000 mg/day; should not exceed 1000 mg/day. Trigeminal neuralgia: initially 200-400 mg/day in 2 divided doses, incr by 200 mg/day in divided doses until pain relieved; usual dose up to 800 mg/day, max 1200 mg/day in 3-4 divided doses. Attempt to reduce dose or discontinue at less than or equal to 3 mth intervals. Mania: initially 200-400 mg/day in 2 divided doses; incr during 1st wk to 800-1000 mg/day; may incr to 1600 mg/day after 2nd wk if no response. Bipolar disorder maintenance: initially 200-400 mg/day in 2 divided doses, incr by 100 mg wkly. Switching between formulations, see full PI. Complex, see full PI
Tegretol CR Tablets Rx (S4)

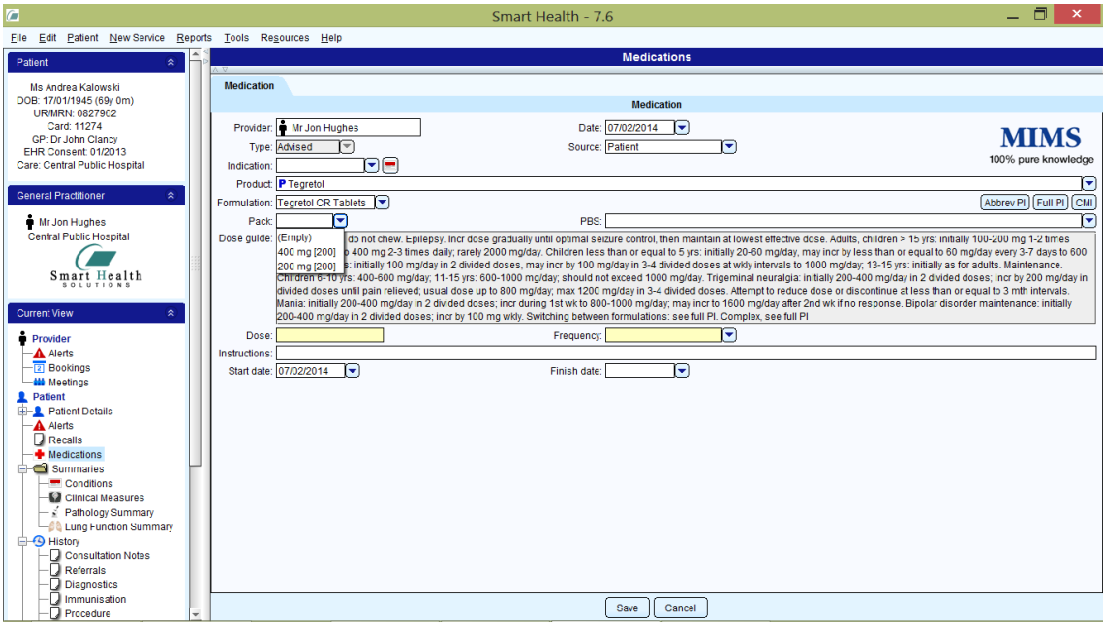
12.6 Formulation

There may also be a choice of formulations.

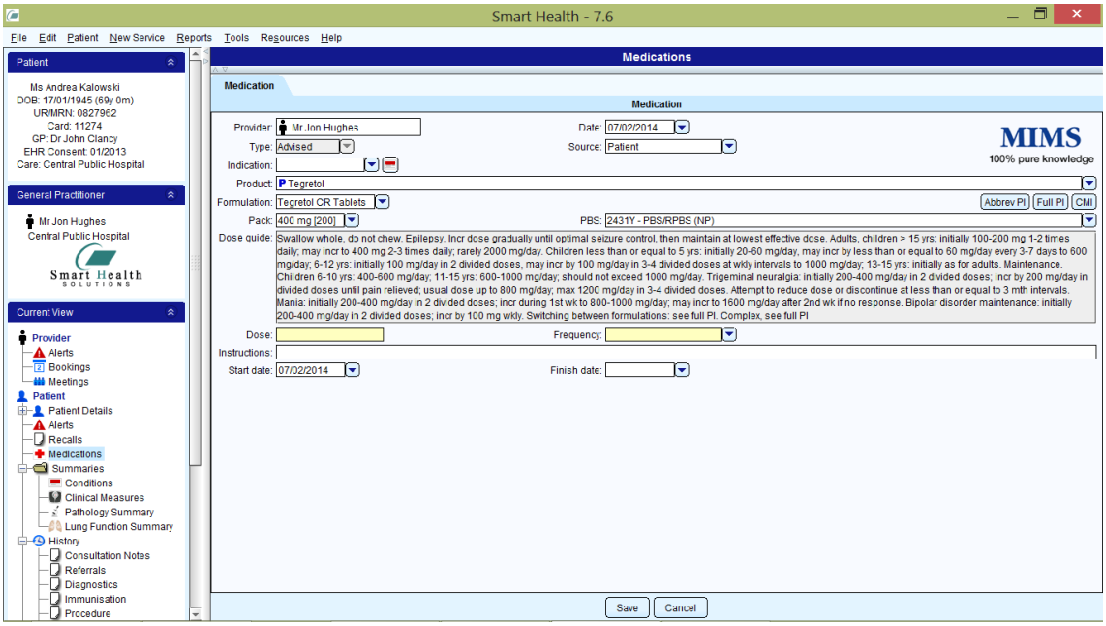


12.7 Pack

When you select a formulation, the Dose Guide is displayed and there may be a choice of Pack:



When you select a Pack, the PBS/RPBS options for that Pack are displayed.


Smart Health - 7.6
File Edit Patient New Service Reports Tools Resources Help
Patient
Ms Andrea Kalowski
DOB: 17/01/1945 (69y 0m)
UR/MRN: 082796C2
Card: 11274
GP: Dr John Clancy
EHR Consent: 01/2013
Care: Central Public Hospital
General Practitioner
Mr Jon Hughes
Central Public Hospital
Smart Health SOLUTIONS
Current View
Provider
Alerts
Bookings
Meetings
Patient
Patient Details
Alerts
Recalls
Medications
Summaries
Conditions
Clinical Measures
Pathology Summary
Lung Function Summary
History
Consultation Notes
Referrals
Diagnostics
Immunisation
Procedure
Medications
Medication
Medication
Provider: Mr Jon Hughes
Date: 07/02/2014
Type: Advised
Source: Patient
Indication:
Product: P Tegretol
Formulation: Tegretol CR Tablets
Abbrev PI
Full PI
CMI
Pack: 400 mg [200]
PBS: 2431Y - PBS/RPBS (NP)
Dose guide: Swallow whole, do not chew. Epilepsy. Incr dose gradually until optimal seizure control, then maintain at lowest effective dose. Adults, children > 15 yrs: initially 100-200 mg 1-2 times daily; may incr to 400 mg 2-3 times daily; rarely 2000 mg/day. Children less than or equal to 5 yrs: initially 20-60 mg/day, may incr by less than or equal to 60 mg/day every 3-7 days to 600 mg/day; 6-12 yrs: initially 100 mg/day in 2 divided doses, may incr by 100 mg/day in 3-4 divided doses at wkly intervals to 1000 mg/day; 13-15 yrs: initially as for adults. Maintenance. Children 6-10 yrs: 400-600 mg/day; 11-15 yrs: 600-1000 mg/day; should not exceed 1000 mg/day. Trigeminal neuralgia: initially 200-400 mg/day in 2 divided doses; incr by 200 mg/day in divided doses until pain relieved; usual dose up to 800 mg/day; max 1200 mg/day in 3-4 divided doses. Attempt to reduce dose or discontinue at less than or equal to 3 mth intervals. Mania: initially 200-400 mg/day in 2 divided doses; incr during 1st wk to 800-1000 mg/day; may incr to 1600 mg/day after 2nd wk if no response. Bipolar disorder maintenance: initially 200-400 mg/day in 2 divided doses; incr by 100 mg wkly. Switching between formulations: see full PI. Complex, see full PI
Dose:
Frequency:
Instructions:
Start date: 07/02/2014
Finish date:
MIMS
100% pure knowledge
Save
Cancel

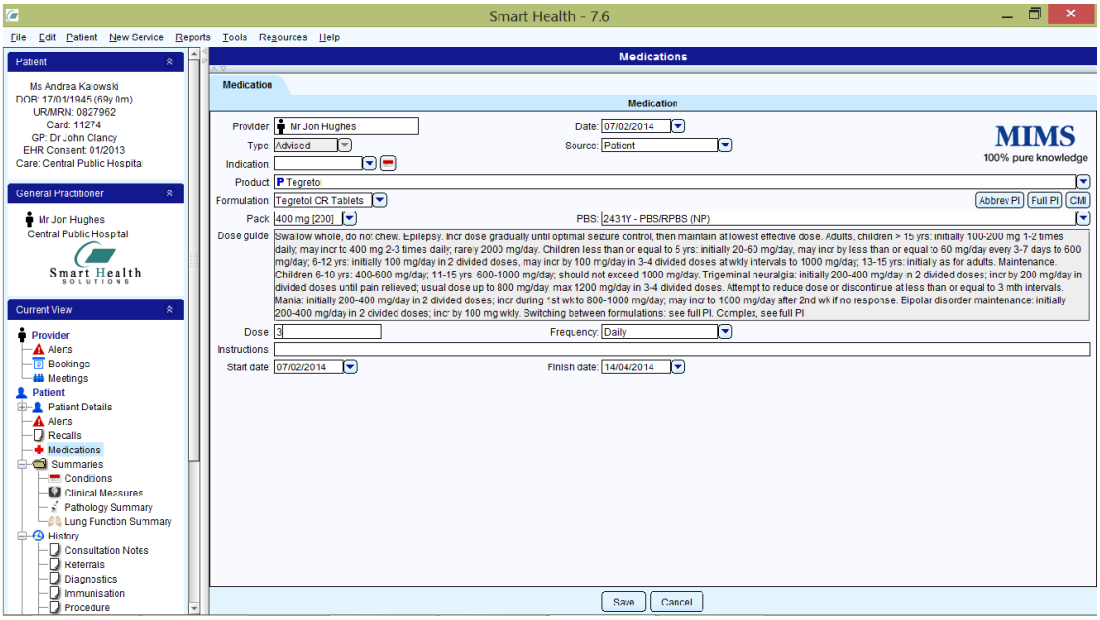
12.8 Authority

When you select an Authority, the details are used to populate the Authority Number and Authority fields in the form (including Streamlined Authority if appropriate).

Select the Approved Indication (if appropriate) and enter the Approval number in the Approval Number field.

12.9 Dose and Frequency

When you enter a Dose and Frequency, the form will automatically calculate an end date for the medication.



12.10 Save

Click Save to save the medication record and add it to the medication summary.

12.11 Completed

Select a medication and click the Completed button to mark that medication as being finished (as of today's date).

12.12 Cease

Select a medication and click the Cease button to end that that medication. You will be prompted to select a reason for ceasing the medication, including an option to record an adverse drug reaction, which will be recorded for that patient in Smart Health.

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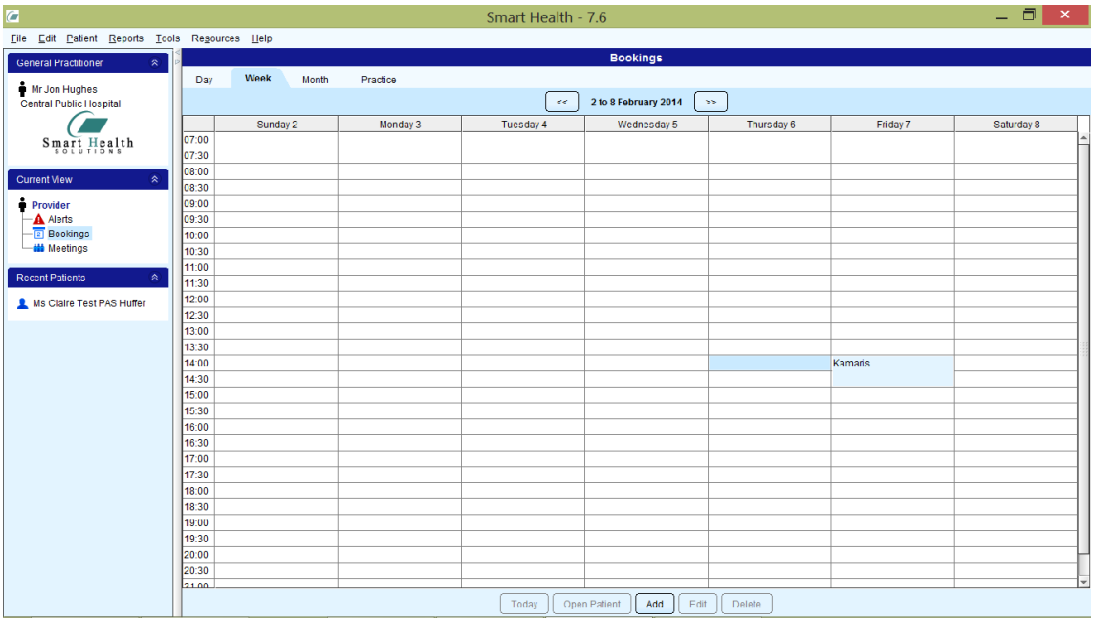
13. BOOKINGS

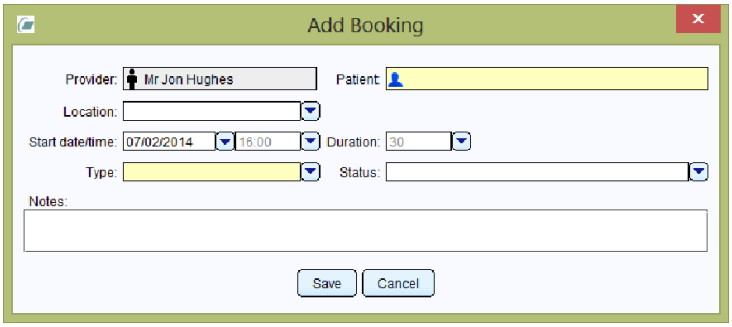
Provider and Practice bookings also appear in the Provider view.

Select Bookings to open the Bookings view.



Click the tabs to move between daily, weekly, monthly and practice (one day for all users) views.

To create a booking in the Calendar, select a time and then click the Add button (or right click the selected time and then click Add).



If a patient record is open, the booking will default to that patient. If a patient record is not open, or wish to make a booking for a different patient, click the Patient field to Search for a patient. A minimum of two letters of the family name, or a UR/MRN, is required to search:

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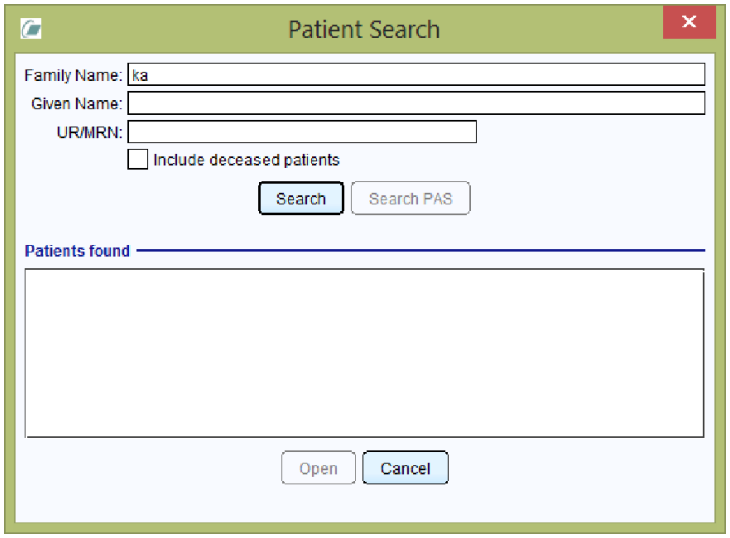
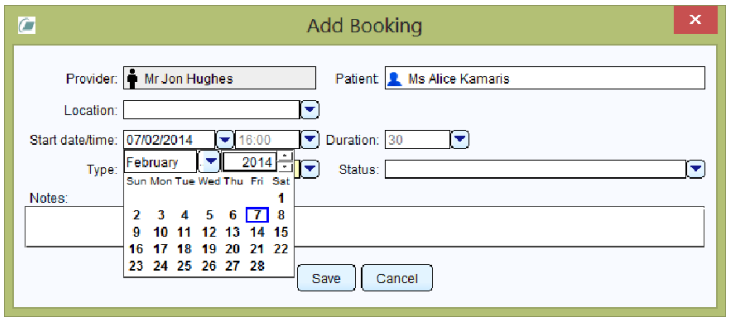
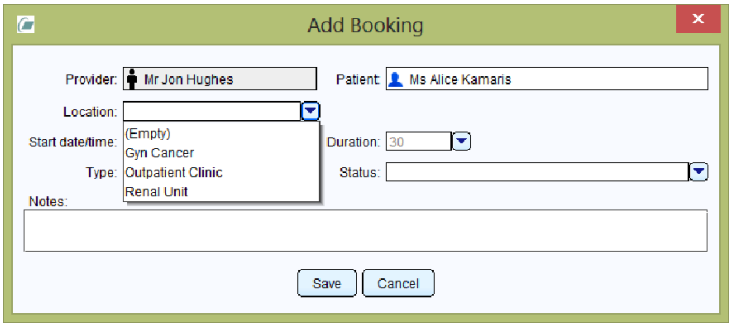


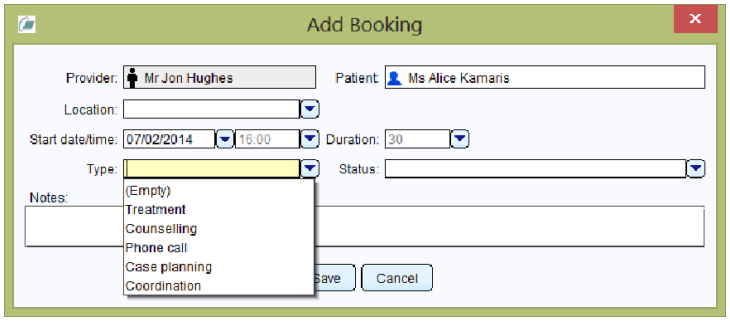
Update the Date and Time for the Booking, if required.



Select the location for the Booking.



Select the Type of Booking:



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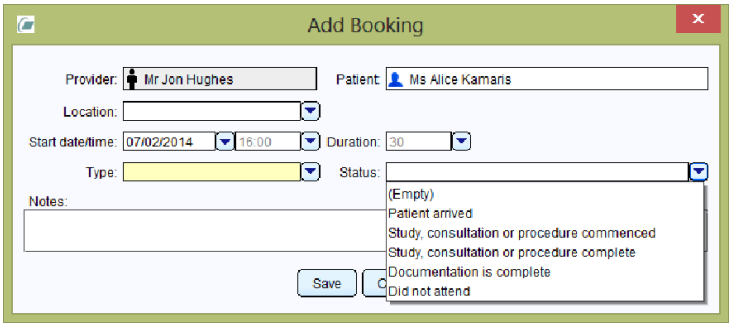
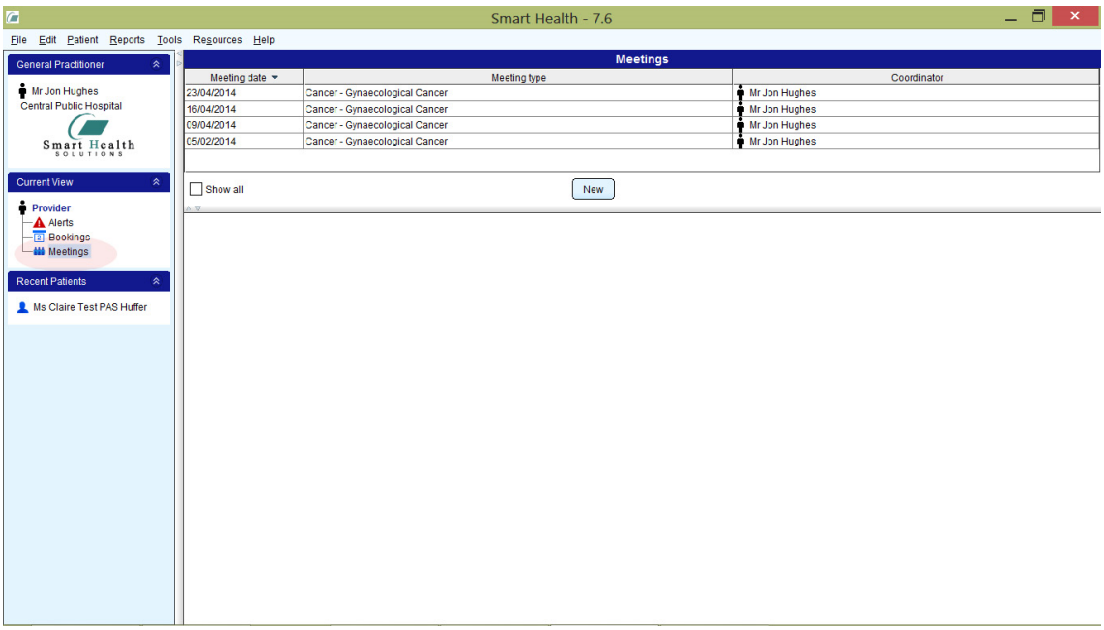
The status of the Booking can be used to record progress of the Booking (or if the patient did not attend).



14. MEETINGS

Smart Health provides functions to create and manage multi-disciplinary team (MDT) meetings. Meeting records are non-patient specific and appear in the Provider view.



The list view shows all future meetings by default, with the next meeting at the bottom of the list.

The list can be sorted by Meeting date, Meeting type and Coordinator, in forward or reverse order. Simply click on the column heading to sort (or reverse sort) using that column.

Click the Show All check box to also display past meetings.

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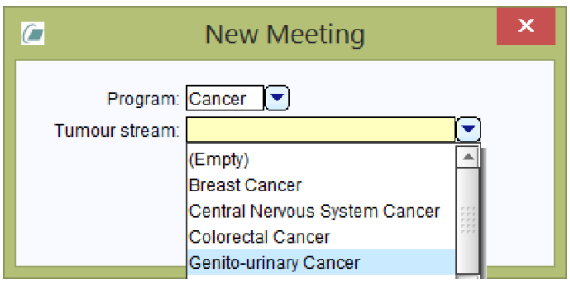
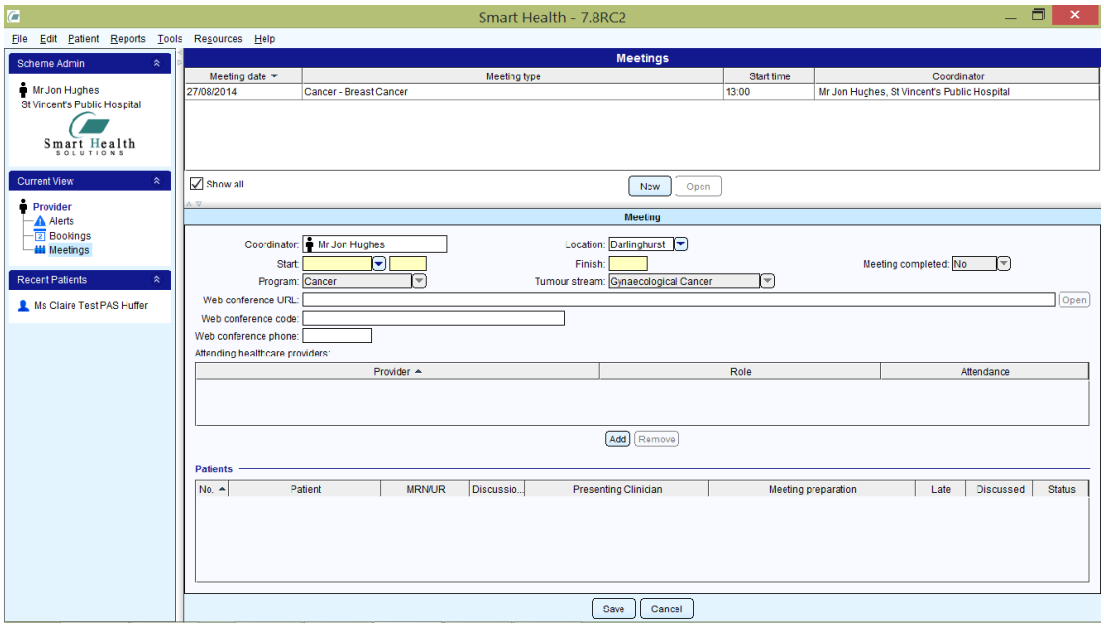
Create a new meeting by clicking “New”.



Select the tumour stream and click OK.



The Start date and time, as well as finish time are the only mandatory fields on this form.

14.1 Edit Meeting

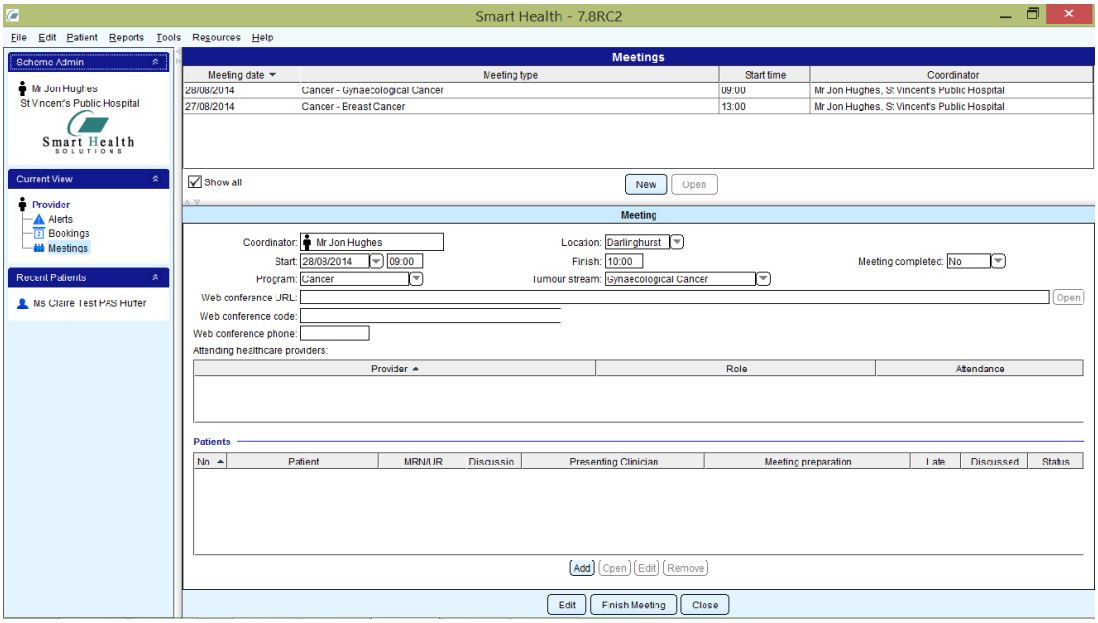
Update meeting details and add providers to the meeting using the Add button under the Provider table. Providers from the previous MDT meeting record will be added automatically.

Select providers and update Attendance to record which providers attended the meeting.

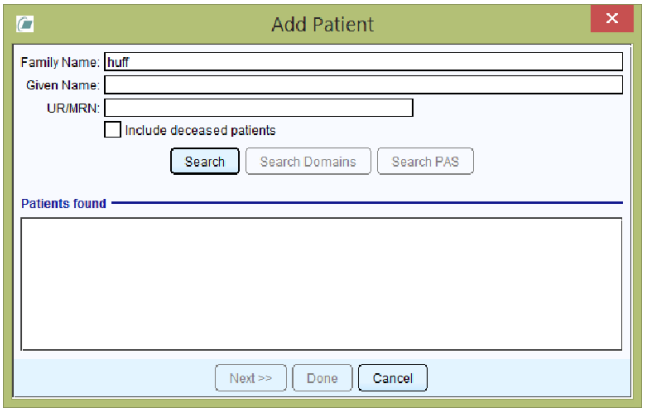
When the meeting details have been updated, click Save.

14.2 Add Patient

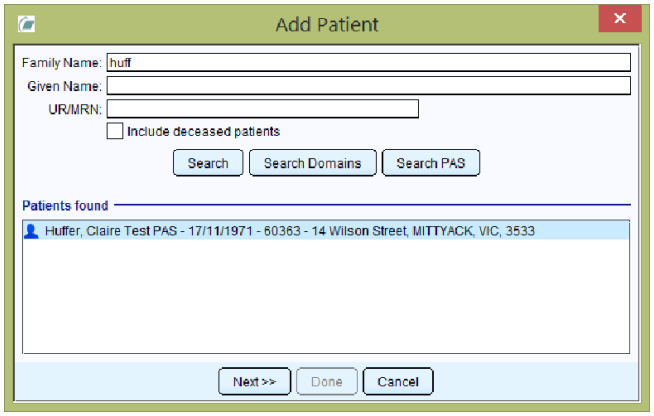
Patients can only be added to the Meeting when the Meeting is not being edited. When the Meeting is saved, an Add button is displayed beneath the Patient table.



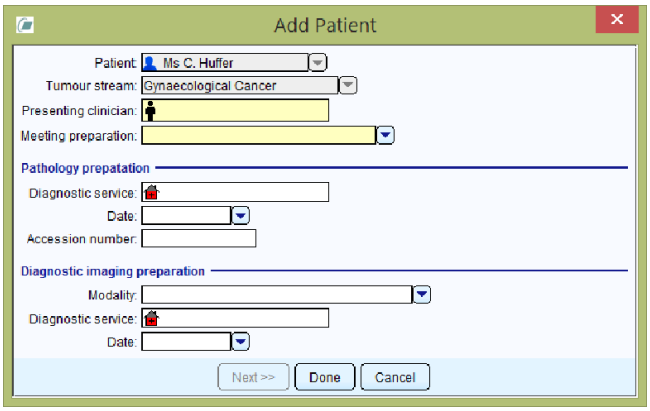
Click the Add button to launch the Add Patient wizard. This opens a search patient dialog. Type two or more letters of the patient's family name or the patient's UR/MRN and click Search to find the patient:



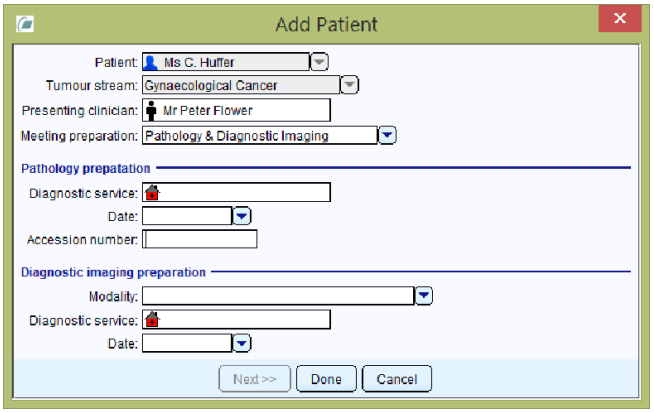
If the patient is found, select the patient from the search dialog and click Next:



The Add Patient Wizard opens a dialog for the user to enter key MDT information:



Update the fields and click Done:



The patient is added to the meeting and an MDT Review record for the patient is created.

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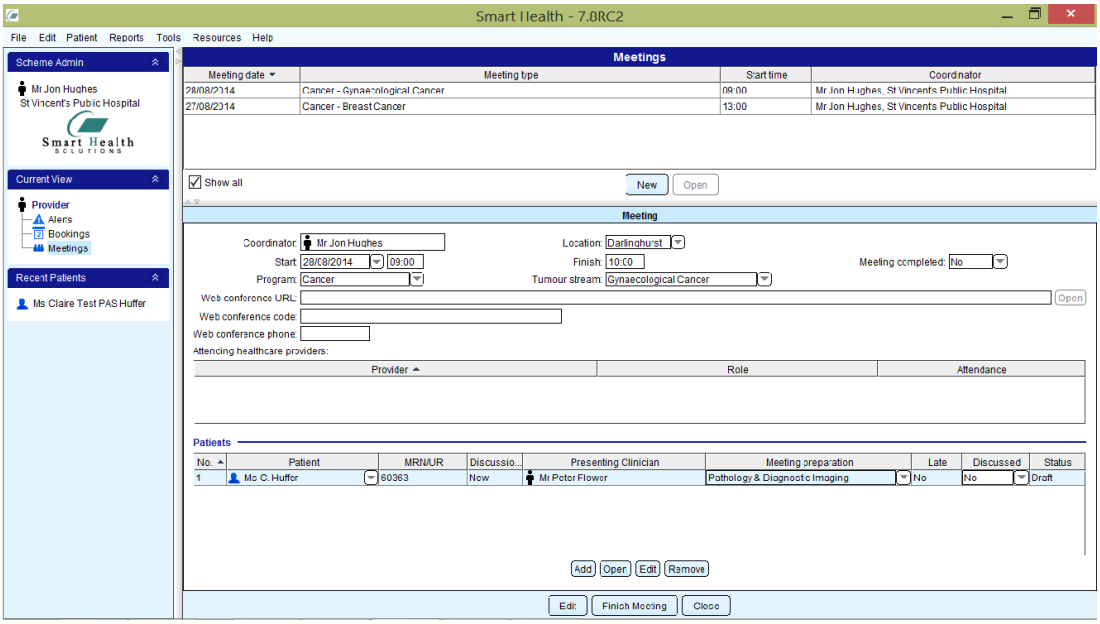
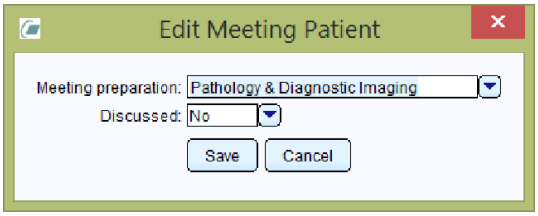


Select a patient from the patient table and click Open to open that patient's MDT Review record (refer to Section 11.1.2).

14.3 Edit Patient Table Details

Select a patient in the Patient Table and click Edit to edit the Meeting Preparation and Discussed fields:



14.4 Finish Meeting

Select the Finish Meeting button to complete the Meeting:

- The MDT Reviews for patients that have been discussed (Discussed=Yes) must all be Saved Final before the Meeting can be Finished.
- Any patients that have not been discussed will automatically be added to the agenda (patient list) of the next meeting for the same program/disease type, if one exists
- MDT Reviews, with a Letter, will be printed or sent to healthcare providers that participated in the MDT Meeting, including patients' GPs. Providers that are Smart Health users will receive an Alert.

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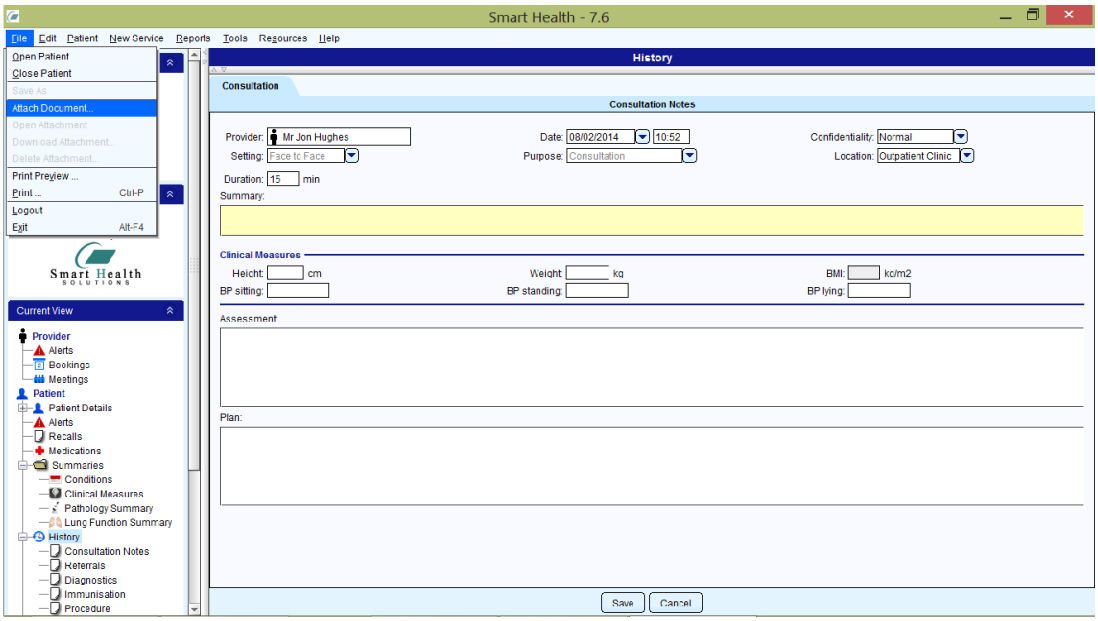
15. OTHER FUNCTIONS

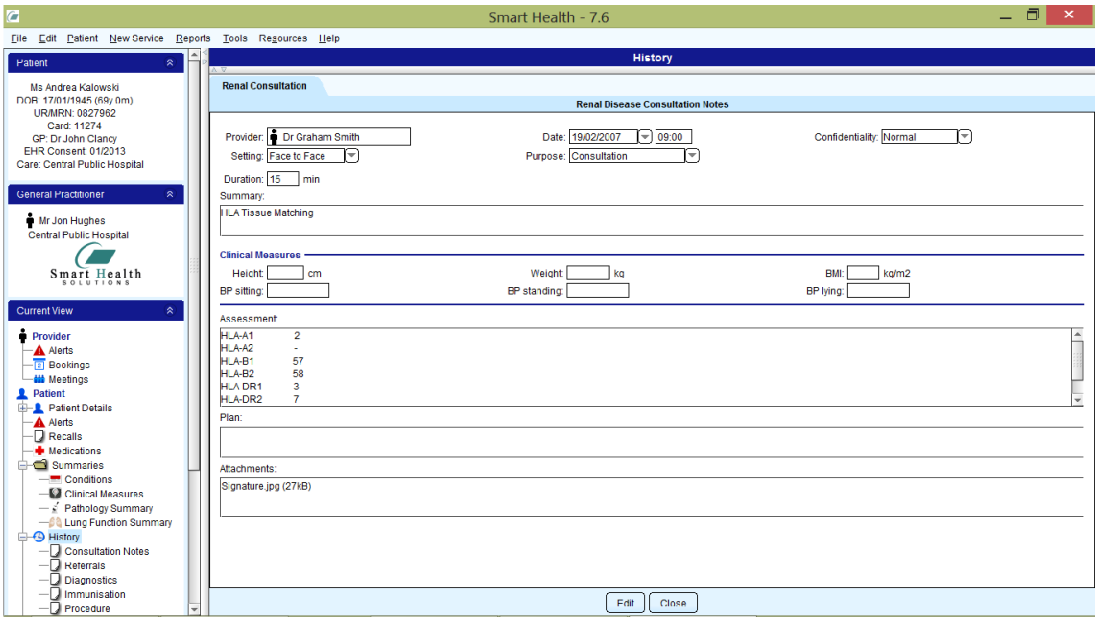
15.1 Attachments

Some clinical event records, such as Consultation Notes, can store attached files as part of the on-line health record. Attachments can be any type of file, including scanned documents, pictures, radiology images, etc.

When an event record that supports attachments has been saved, select Attach Document from the File main menu.



Select the file to be uploaded and attached to the record. When the upload is complete, the clinical record will include the attachment details:

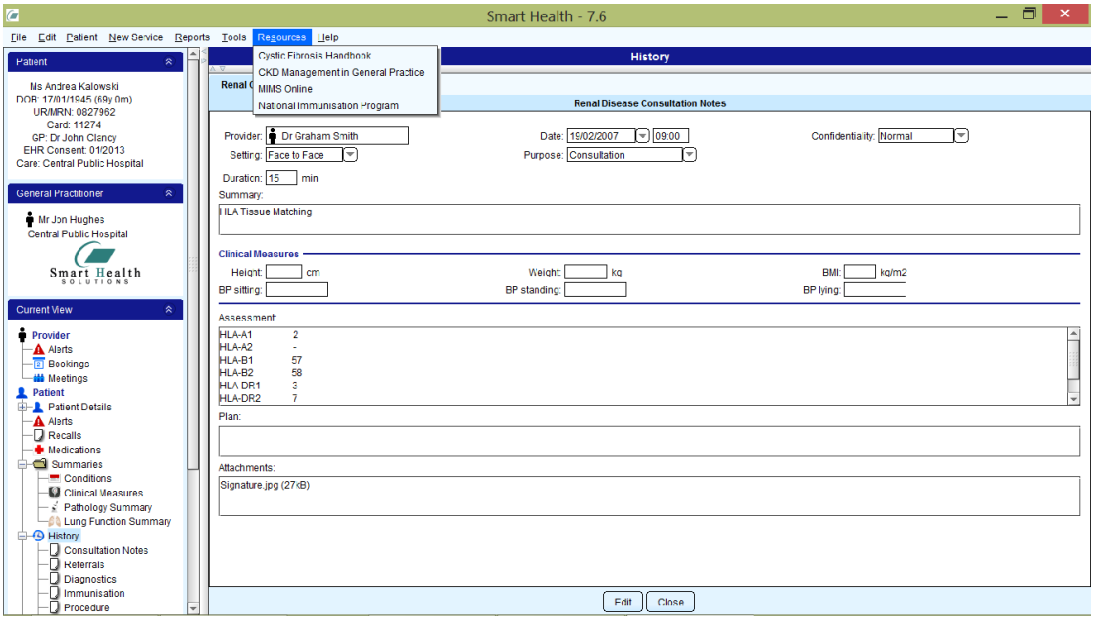


15.2 Resources

Smart Health includes links to on-line resources that support managed eHealth programs, including kidney disease and cystic fibrosis.

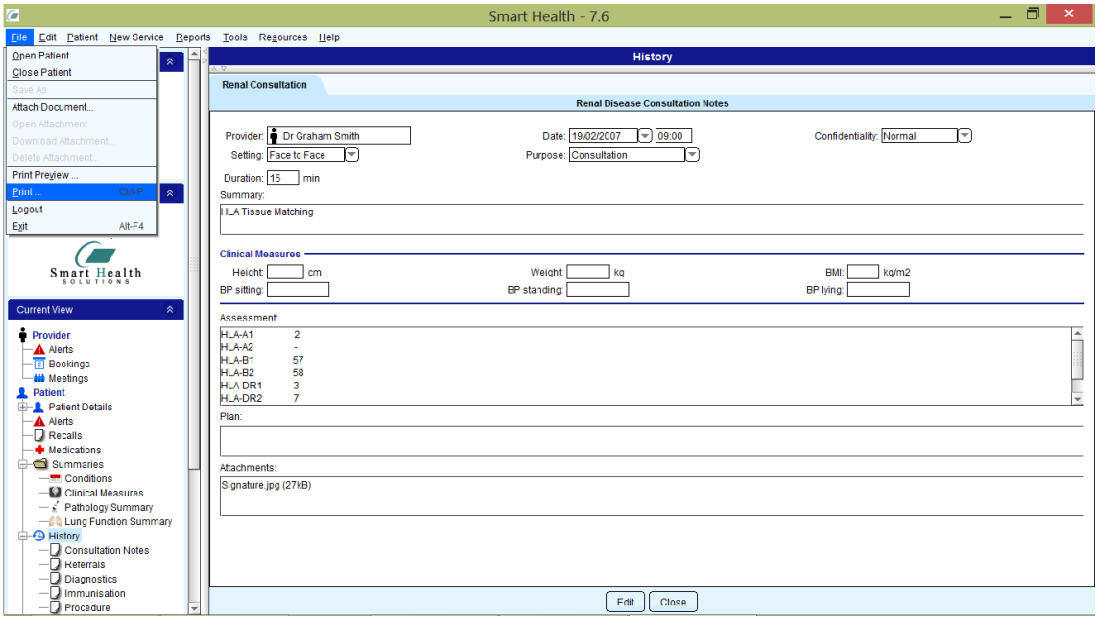
The entries in the Resource Menu are specific to each Practice (Medical Group) and are maintained by Administration functions (Administration User Guide).

Select the Resource menu to open one of these links.



15.3 Printing

When any clinical event record, summary or patient detail view is open, select Print from the File main menu to print the record:



Print starts the operating system's print processor to print the record to your selected printer, or to a file if you have a PDF generator installed on your workstation.

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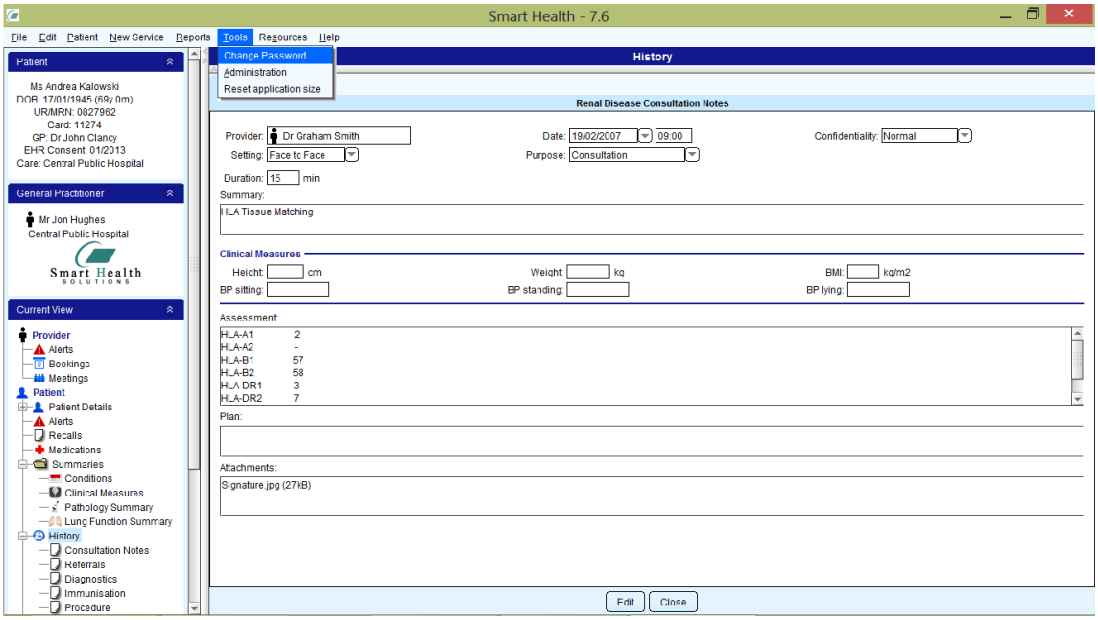
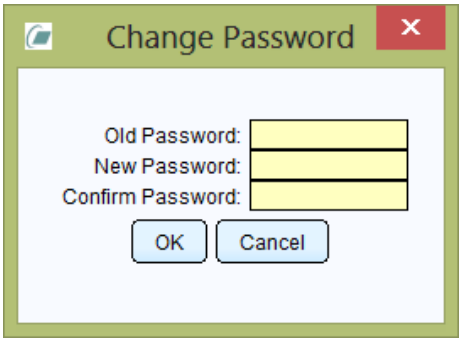
15.4 Change Password

You can change your smartcard password by selecting Change Password from the Tools main menu.



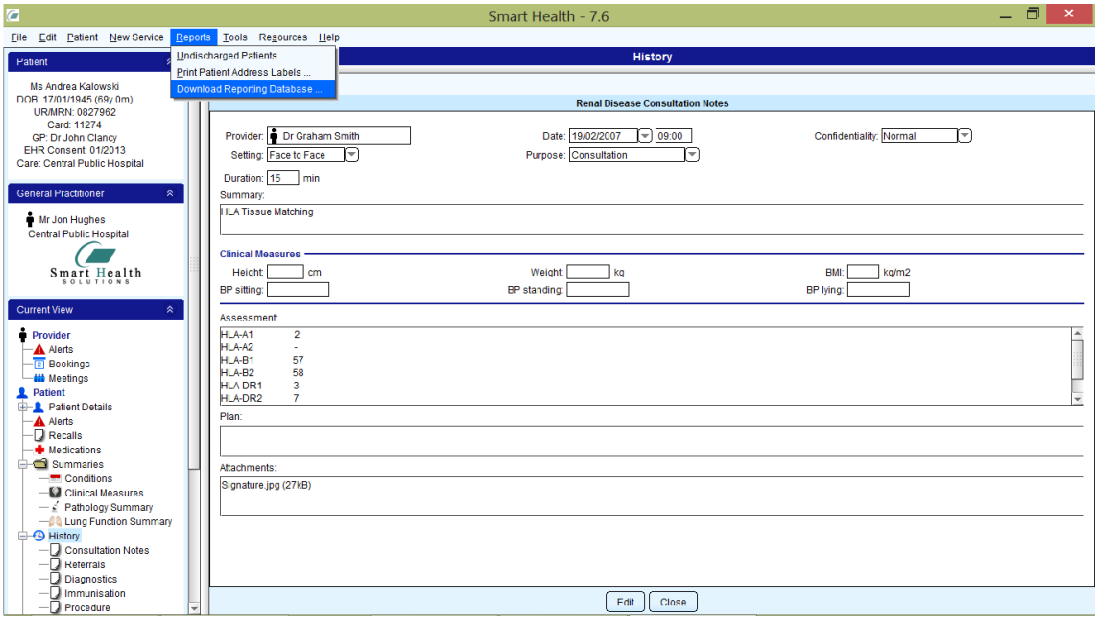
When the Change Password screen is displayed, insert your smartcard in the card reader, type your old password in the first field, your new password in both of the new password fields and click OK:



15.5 Download Reports

Each Smart Health practice can download a database of all patient clinical data for to use for local queries and reporting.

Select Download Reporting Database from the Tools main menu to download the reporting database.



A standard file explorer tool will let you select the location to store the downloaded file.

The downloaded file is a back up of an SQL/Server database. Restore the backed up database to an SQL/Server 2005 on your local network and use a standard SQL Query/Reporting tool (such as Business Objects, Crystal Reports, SAS) to generate reports locally. A specification for the Reporting Database is available from Smart Health.

In some practices, these reporting database files are downloaded automatically every week by IT Services.

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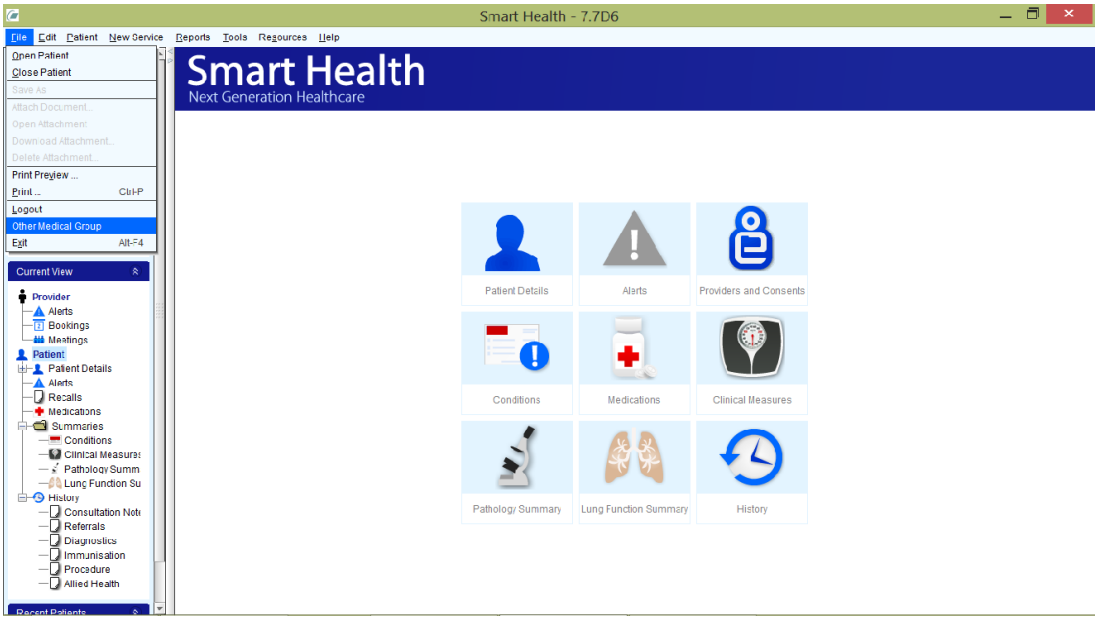
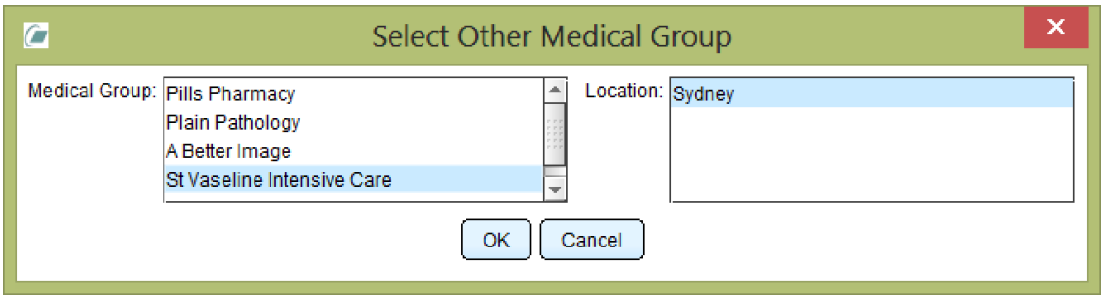
15.6 Other Medical Group

Users who are members of more than one Medical Group (practice) can change the medical group to which they are logged on without having to log off and re-log on with their smartcards.

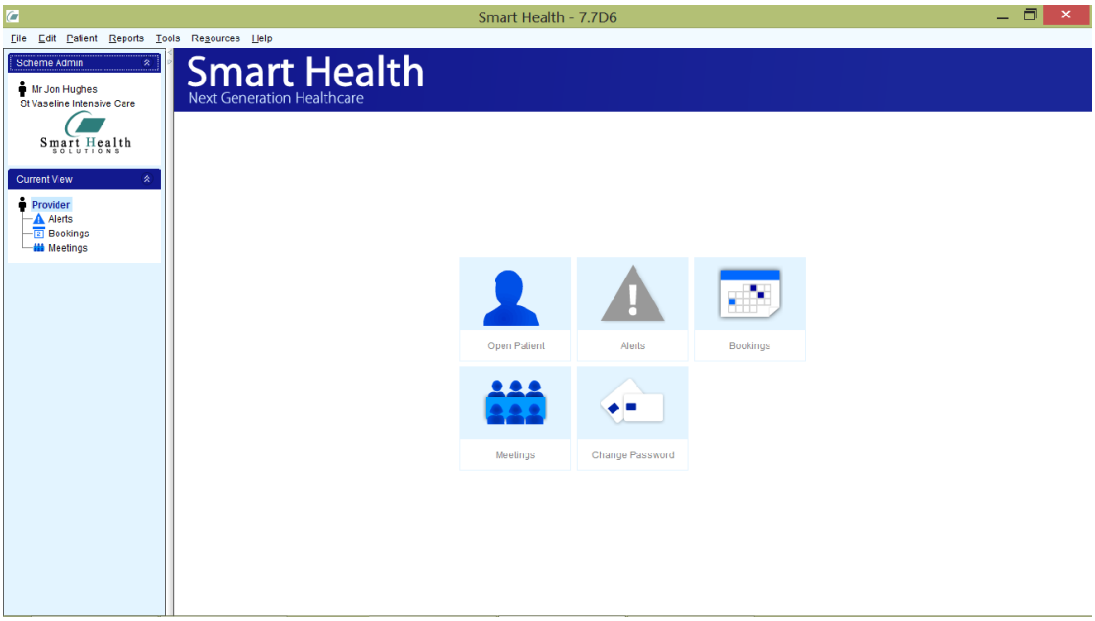
Select File\Other Medical Group from the main menu:



A dialog is displayed that prompts the user to select the Medical Group to which they want to log on, as well as the Medical Group Location:

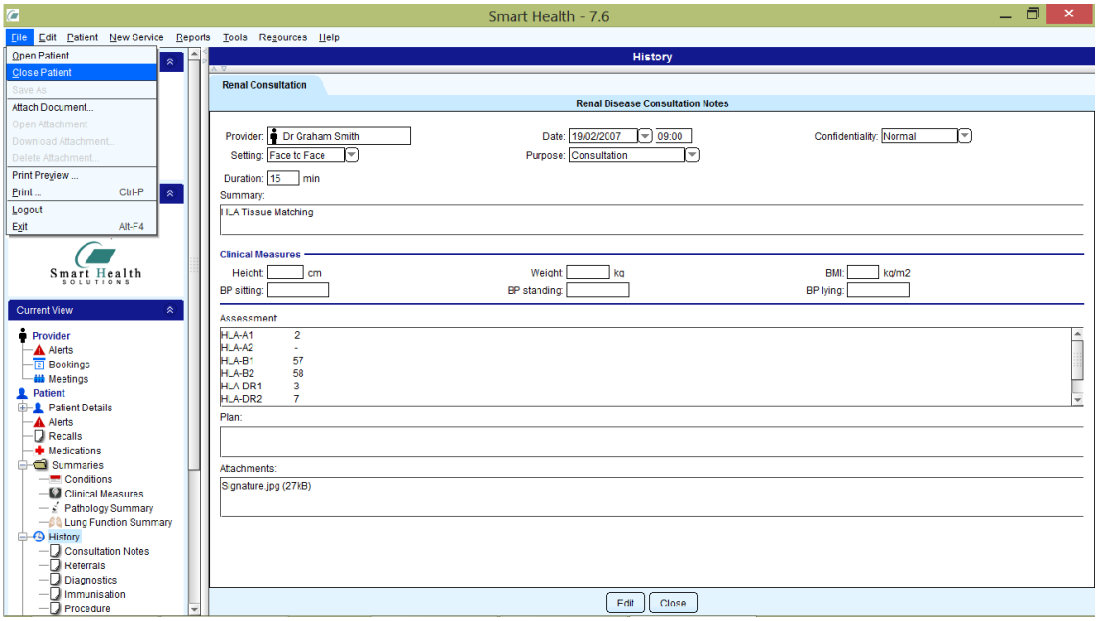


When the user clicks OK, any open patient records are closed (the user is prompted to save any unsaved records), the patient is closed and the user is logged on to the selected Medical Group:

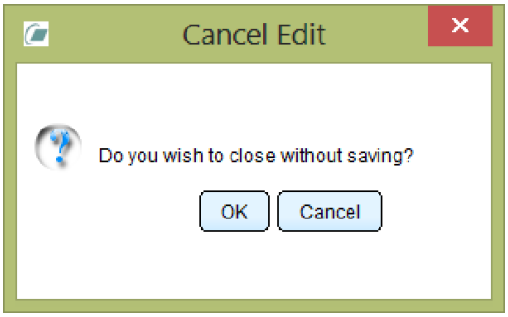


16. CLOSE PATIENT

To close a patient, select Close Patient from the File main menu.

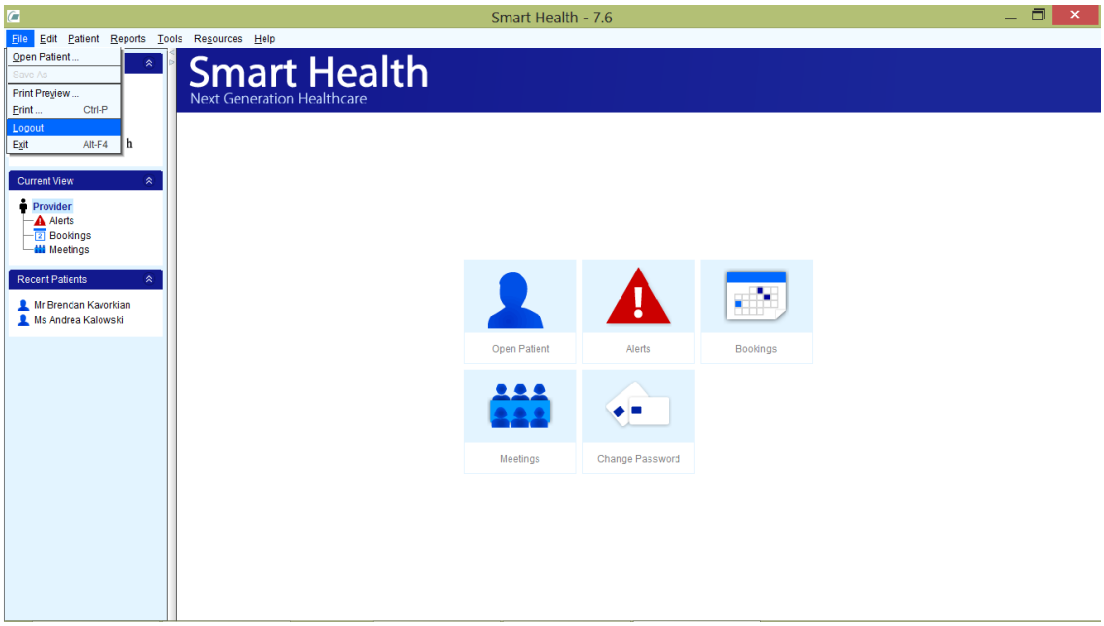


You may be prompted to save or discard any unsaved records:

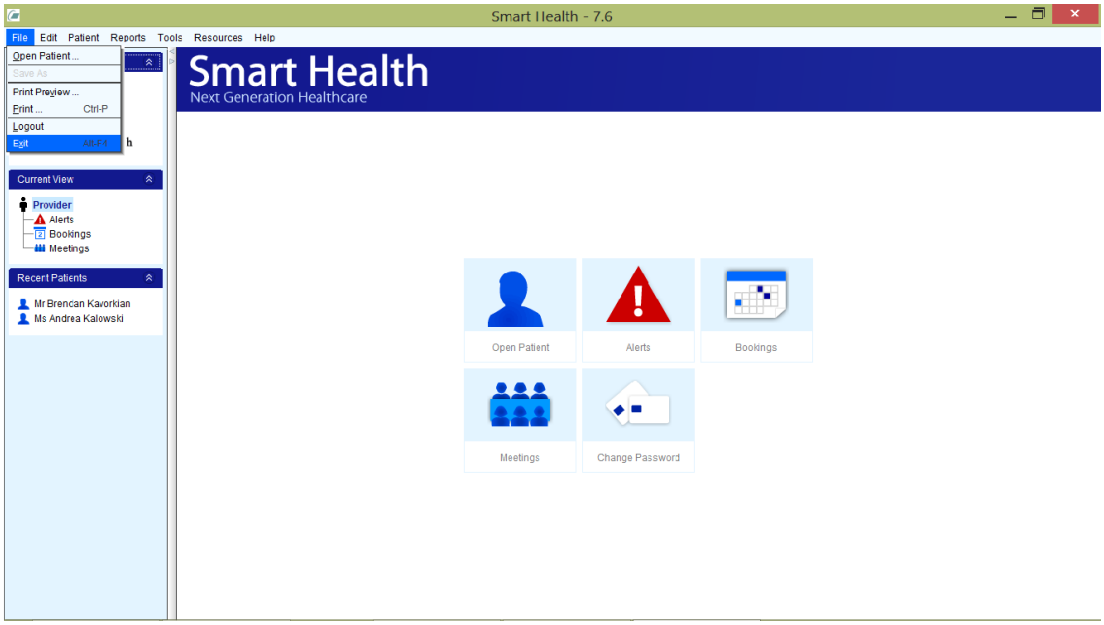


17. LOG OUT AND EXIT

Select Logout from the File main menu to log out and leave the Smart Health logon screen on the desktop:



Select Exit from the File main menu to log out and close the Smart Health application:



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18. ACKNOWLEDGEMENTS

This product includes software developed by IAIK of Graz University of Technology.

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